Information Resource Center
MDG
8.6

PB-236 554

VOLUME IV

MEDICAID MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN FOR TITLE XIX

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service

REPORTS
RA
412
.4
M4337
1973
v.4

This report is distributed by the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161

Paper Copy

Microfiche

BIBLIOGRAPHIC DATA SHEET	1. Report No. SRS-75-06004	2.	3. Recipient's Accession No. PB-236 554
4. Title and Subtitle MEDICAID MANAGEMENT INFORMATION SYSTEM, GENERAL SYSTEMS DESIGN FOR TITLE XIX. VOLUME IV. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM			5. Report Date December 3, 1973 6.
7. Author(s) DIVISION OF MEDICAID SYSTEMS			8. Performing Organization Rept. No.
9. Performing Organization Name and Address OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR INFORMATION SYSTEMS SOCIAL AND REHABILIATION SERVICE, DHEW - 330 C STREET, S. W. WASHINGTON, D. C. 20201			10. Project/Task/Work Unit No. 11. Contract/Grant No.
12. Sponsoring Organization Name and Address SAME AS (9)			13. Type of Report & Period Covered GENERAL SYSTEMS DESIGN 14.

15. Supplementary Notes
THIS PUBLICATION SUPERSEDES THE EARLIER INITIAL PRINTING OF PUBLICATION NO. PB-202-993-04

16. Abstracts

THE PRINCIPAL FUNCTIONS OF THE MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM OF THE MODEL MEDICAID MANAGEMENT INFORMATION SYSTEM ARE TO: FURNISH THE SINGLE STATE AGENCY WITH INFORMATION TO SUPPORT THE MANAGEMENT REVIEW, EVALUATION, AND DECISION MAKING PROCESSES; PROVIDE MANAGEMENT WITH FINANCIAL DATA FOR PROPER FISCAL PLANNING AND CONTROL; PROVIDE MANAGEMENT WITH INFORMATION TO ASSIST IN THE DEVELOPMENT OF IMPROVED MEDICAL ASSISTANCE POLICY AND REGULATIONS; MONITOR THE PROGRESS OF CLAIMS PROCESSING OPERATIONS, INCLUDING THE STATUS OF PROVIDER PAYMENTS; ANALYZE RECIPIENT PARTICIPATION IN TERMS OF THE NATURE AND EXTENT OF SERVICES RECEIVED; PROVIDE THE NECESSARY DATA TO SUPPORT FEDERAL REPORTING REQUIREMENTS.

17. Key Words and Document Analysis. 17a. Descriptors

* MEDICAL SERVICES,
* INFORMATION SYSTEMS,
HEALTH AND WELFARE SYSTEMS.
MANAGEMENT REVIEW/CONTROL
COMPUTER PROGRAMS.

17b. Identifiers/Open-Ended Terms

* MANAGEMENT INFORMATION SYSTEMS,
MMIS (MEDICAID MANAGEMENT INFORMATION SYSTEM),
* MEDICAID MANAGEMENT INFORMATION SYSTEM.

17c. COSATI Field/Group

18. Availability Statement	19. Security Class (This Report)	21. No. of Pages
NATIONAL TECHNICAL INFORMATION SERVICE 5285 PORT ROYAL ROAD SPRINGFIELD, VA. 22161	UNCLASSIFIED	270
	20. Security Class (This Page) UNCLASSIFIED	22. Price

THIS FORM MAY BE REPRODUCED

RA
412.4
.M4337
1973
v.4

MEDICAID
MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN
FOR TITLE XIX

VOLUME IV: Management and Administrative Reporting Subsystem

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social And Rehabilitation Service
Associate Administrator For Information Systems

Division of Medicaid Systems
SRS-75-06004

MEDICAID
MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN

TABLE OF CONTENTS

		PAGE NUMBER
VOLUME I	INTRODUCTION	
	A. General	ix
	B. Documentation Organization	ix
	C. Flowchart Symbol Explanation	x
	D. Documentation Nomenclature	xiii
	E. Transmittal of Revisions	xiv
Section I	MODEL SYSTEM OVERVIEW	
	A. Background	I-1
	B. Objective	I-2
	C. General Design Considerations	I-2
	1. Design Scope	I-2
	2. General Design Usage	I-2
	3. Modular Design Concept	I-3
	4. Equipment Configuration	I-4
	D. Adoption of the Model System	I-5
	E. Management Narratives	I-6
	1. Recipient Subsystem	I-9
	2. Provider Subsystem	I-10
	3. Claims Processing Subsystem	I-10
	4. Reference File Subsystem	I-12
	5. Surveillance and Utilization Review Subsystem	I-12
	6. Management and Administrative Reporting Subsystem	I-13
	F. Model System Highlights	I-14
	G. Model System Key Information Flow	I-15
Section II	RECIPIENT SUBSYSTEM	
	A. Subsystem Summary	II-1
	1. Objectives	II-1
	2. General Description	II-1
	3. Information Flow Diagram	II-4
	B. Design Elements	II-7
	1. Constraints and Assumptions	II-7
	2. Design Considerations	II-8
	3. Controls and Audit Trails	II-14
	C. Processing Flow	II-17
	1. Introduction	II-17
	2. Functional Flow Diagram	II-17
	3. Module Descriptions	II-21

		PAGE NUMBER
	D. Subsystem Outputs	II-69
	E. Subsystem Inputs	II-109
	F. Subsystem Files	II-125
	G. Data Element Input/Output Matrix	II-135
Section III	PROVIDER SUBSYSTEM	
	A. Subsystem Summary	III-1
	1. Objectives	III-1
	2. General Description	III-1
	3. Information Flow Diagram	III-3
	B. Design Elements	III-7
	1. Constraints and Assumptions	III-7
	2. Design Considerations	III-7
	3. Controls and Audit Trails	III-12
	C. Processing Flow	III-14
	1. Introduction	III-14
	2. Functional Flow Diagram	III-14
	3. Module Descriptions	III-17
	D. Subsystem Outputs	III-56
	E. Subsystem Inputs	III-94
	F. Subsystem Files	III-112
	G. Data Element Input/Output Matrix	III-121
VOLUME II	INTRODUCTION	
	A. General	vii
	B. Documentation Organization	vii
	C. Flowchart Symbol Explanation	viii
	D. Documentation Nomenclature	xi
Section IV	CLAIMS PROCESSING SUBSYSTEM	
	A. Subsystem Summary	IV-1
	1. Objectives	IV-1
	2. General Description	IV-1
	3. Information Flow Diagram	IV-2
	B. Design Elements	IV-7
	1. Constraints and Assumptions	IV-7
	2. Design Considerations	IV-7
	3. Controls and Audit Trails	IV-10
	C. Processing Flow	IV-13
	1. Introduction	IV-13
	2. Functional Flow Diagram	IV-14
	3. Module Descriptions	IV-16
	D. Subsystem Outputs	IV-85
	E. Subsystem Inputs	IV-125
	F. Subsystem Files	IV-143
	G. Data Element Input/Output Matrix	IV-179

PAGE NUMBER

Section V REFERENCE FILE SUBSYSTEM

A. Subsystem Summary V-1
1. Objectives V-1
2. General Description V-1
B. Design Elements V-3
1. Constraints and Assumptions V-3
2. Design Considerations V-3
3. Controls and Audit Trails V-4
C. Processing Flow V-5
1. Introduction V-5
2. Functional Flow Diagram V-5
3. Module Descriptions V-9
D. Subsystem Outputs V-25
E. Subsystem Inputs V-41
F. Subsystem Files V-49
G. Data Element Input/Output Matrix V-63

VOLUME III INTRODUCTION

A. General vii
B. Documentation Organization vii
C. Flowchart Symbol Explanation viii
D. Documentation Nomenclature ix

Section VI SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

A. Subsystem Summary VI-1
1. Objectives VI-1
2. General Description VI-1
B. Design Elements VI-7
1. Constraints and Assumptions VI-7
2. Design Considerations VI-8
3. Controls and Audit Trails VI-11
C. Processing Flow VI-13
1. Introduction VI-13
2. Functional Flow Diagram VI-15
3. Module Descriptions VI-17
D. Subsystem Outputs VI-67
1. Management Summary Reports VI-69
2. Summary Profile Reports VI-141
3. Treatment Analysis Reports VI-229
4. Claim Detail Reports VI-245
5. Requested Special Reports VI-253
E. Subsystem Inputs VI-259
F. Subsystem Files VI-299

		PAGE NUMBER
VOLUME IV	INTRODUCTION	
	A. General	vii
	B. Documentation Organization	vii
	C. Flowchart Symbol	viii
	D. Documentation Nomenclature	xi
Section VII	MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM	
	A. Subsystem Summary	VII-1
	1. Objectives	VII-1
	2. General Description	VII-2
	3. Information Flow Diagram	VII-7
	B. Design Elements	VII-13
	1. Constraints and Assumptions	VII-13
	2. Design Considerations	VII-15
	3. Controls and Audit Trails	VII-18
	C. Processing Flow	VII-21
	1. Introduction	VII-21
	2. Functional Flow Diagram	VII-22
	3. Module Descriptions	VII-25
	D. Subsystem Outputs	VII-57
	1. Outputs List	VII-59
	a. Administrative Area	VII-59
	b. Operations Area	VII-60
	c. Provider Relations Area	VII-60
	d. Recipient Relations Area	VII-62
	E. Subsystem Inputs	VII-243
	F. Subsystem Files	VII-261
	G. Data Element Input/Output Matrix	VII-269
	H. Work Item Input/Output Matrix	VII-271
VOLUME V		
Section VIII	APPENDIX	
	A. Glossary	VIII-3
	B. Data Element Dictionary	VIII-19

INTRODUCTION

A. GENERAL

The General Systems Design of the Model Medicaid Management Information System is a product of the Division of Management Information and Payment Systems, Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

The General Systems Design is comprised of an introduction, a management overview or executive brief, six sections describing individual subsystems within the Model System, and an Appendix. This material has been grouped for convenience of handling into five volumes.

B. DOCUMENTATION ORGANIZATION

The General Systems Design documentation for each of the six subsystems that make up the Model System is presented within its respective section as follows:

1. Subsystem summary, where the subsystem objectives are itemized and a general description of the subsystem is provided.

2. Design elements, where all assumptions and constraints imposed are listed, where considerations affecting the design of the subsystem are discussed, and where the controls and audit trails established to insure subsystem integrity are listed.

3. Processing flow, where a detail description is furnished of how each module functions within the subsystem.

4. Subsystem outputs, where each major output is defined as to purpose, distribution, content, and format.

5. Subsystem inputs, where each major input is defined as to use, source, and data element content.

6. Subsystem files, where each major file is defined as to function and data element content.

7. Input/Output matrix, where data elements used in a subsystem are identified as to their source and distribution.

Volume V - Appendix contains the following General Systems Design documentation:

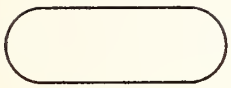
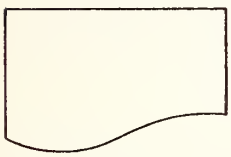
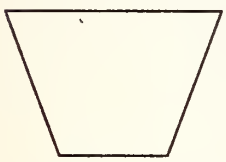
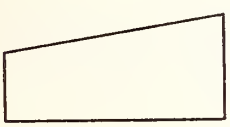
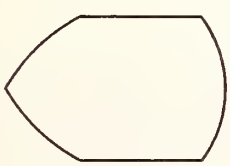
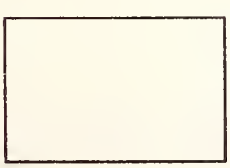
1. A glossary which indicates the specialized meaning of various terms used in the design documentation.

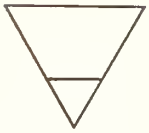
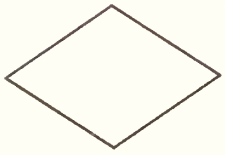
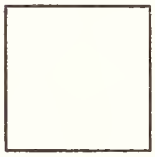
2. Data element definitions which provide an explanation of each data element, and where applicable, a recommended code structure.

C. FLOWCHART SYMBOL EXPLANATION

In certain portions of the General Systems Design documentation flowcharts are used to graphically describe the processing flow. An explanation of the symbols employed is furnished on the following pages.

FLOWCHART SYMBOLS

SYMBOL	EXPLANATION
	Terminal point - indicates exit from a module to another module or subsystem; indicates entry to a module from another module or subsystem.
	Document - computer printed output; manually created reports; source documents.
	Manual process step - a step in which no equipment, other than normal clerical devices, is used.
	Keying - a process step involving the generation of machine-readable records using a key-driven device.
	Manual input - information input by on-line keyboards.
	Display - information display by on-line video devices.
	Computer processing step - processing which takes place in the computer.

SYMBOL	EXPLANATION
	Off-line file - a file of non-machine-readable data such as documents.
	Decision - a processing step (manual or computer) in which a decision is made and one of several alternatives selected.
	Off-line equipment processing - a processing step which utilizes off-line equipment (e.g., sorter, microfilm machine).
	Input/Output function in card medium.
	On-line file - a file composed of machine-readable data (e.g., drum, tape, disk).
	On-page connector - indicates entry to a process from a point on the same page; indicates exit to a process on the same page.
	Off-page connector - indicates entry to a process from another page; indicates exit to a point on another page.

D. DOCUMENTATION NOMENCLATURE

1. Design Element Identification

As a part of the General Design documentation for individual subsystems, specifications for inputs, outputs, and data files are provided. To provide a means of unique identification for these design elements, the following reference scheme is used:

XX-Y-ZZ

where XX identifies the source subsystem for the design element per the following abbreviations:

- RS Recipient Subsystem
- PS Provider Subsystem
- CP Claims Processing Subsystem
- RF Reference File Subsystem
- SU Surveillance and Utilization Review Subsystem
- MR Management and Administrative Reporting Subsystem

where Y identifies the design element per the following code:

- O Output
- I Input
- F File

where ZZ is a unique two digit number identifying the particular design element.

2. Data Element Numbering

Each subsystem serves as a point of entry for various data elements that are collected, processed, and displayed on one or more outputs from the Model System. The following ranges of numbers are allocated by subsystem for assignment to data elements that originate in that subsystem:

- 100-199 Recipient Subsystem
- 200-299 Provider Subsystem
- 300-499 Claims Processing Subsystem

500-599 Reference File Subsystem

600-699 Management and Administrative Reporting Subsystem

700-799 Surveillance and Utilization Review Subsystem

3. Flowchart Connectors

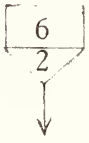
As a part of the documentation of each subsystem, module flowcharts are furnished to describe the processing flow. In some instances, more than one flowchart page is required for a module. This situation results in the need for processing connectors as follows:

where X is the number of a specific flowchart page. If the flowchart indicates an exit connector, then X is the page to which exit is made. If the flowchart indicates an entry connector, then X is the page upon which entry is made.

Y is the unique number designating a particular exit or entry point on the page.

For example:

From Page 4 exit connector

To Page 6 entry connector 

MEDICAID

MANAGEMENT INFORMATION SYSTEM

SECTION VII

MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM (MARS)

SECTION VII

MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

TABLE OF CONTENTS

		PAGE NUMBER
A.	SUBSYSTEM SUMMARY	
	1. Objectives	VII-1
	2. General Description	VII-2
	3. Information Flow Diagram	VII-7
B.	DESIGN ELEMENTS	
	1. Constraints and Assumptions	VII-13
	2. Design Considerations	VII-15
	3. Controls and Audit Trails	VII-18
C.	PROCESSING FLOW	
	1. Introduction	VII-21
	2. Functional Flow Diagram	VII-22
	3. Module Descriptions	VII-25
D.	SUBSYSTEM OUTPUTS	
	1. Outputs List	
	a. Administrative Area	VII-64
	b. Operations Area	VII-88
	c. Provider Relations Area	VII-106
	d. Recipient Relations Area	VII-214
E.	SUBSYSTEM INPUTS	VII-243
F.	SUBSYSTEM FILES	VII-261
G.	DATA ELEMENT INPUT/OUTPUT MATRIX	VII-269
H.	WORK ITEM INPUT/OUTPUT MATRIX	VII-271

VII. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

A. SUBSYSTEM SUMMARY

1. Objectives

The rapid expansion of medical assistance programs in recent years has amplified the difficult task of effectively planning, directing and controlling Title XIX programs. The task of administering these dynamic programs requires the application of good business procedures and sound fiscal practices to what has emerged as an extremely large business. In most States the programs involve millions of dollars, thousands of medical professionals, and hundreds of thousands of individuals receiving service. As these numbers increase, the number of management tasks do not multiply, they simply grow in magnitude. To conduct the administration activity of these ever increasing programs requires a large staff of Medicaid personnel. As the programs increase, the staff workload increases and the communication of vital information becomes less frequent as staff members become more heavily committed. The magnitude of the tasks draws the managers of the program and the working staff further apart since time is not available to summarize information for management review. The resulting communications gap must be reduced, if not eliminated.

It is essential, therefore, that a means be developed to provide timely, concise and meaningful information to program management which reflects the key areas of program activity. This information must be available to support the decision making processes inherent in the development of effective medical delivery systems which are acceptable to both recipients and providers. In most instances program management is forced to react to each situation as it arises rather than positively plan program activity and avoid undesirable situations.

The difference between planning and reacting is information. The objective of the Management and Administrative Reporting Subsystem is to provide this difference by presenting to program management, concise, meaningful information which measures the pulse of program activity. This subsystem has, therefore, been developed to accomplish the following primary objectives:

a. Establish information reporting to assist management in fiscal planning and control.

b. Provide information required in the review and

development of medical assistance policy and regulations.

c. Monitor the progress of claims processing activity and provide summary reports which reflect the current status of payments.

d. Review provider performances to determine the adequacy and extent of participation and service delivery.

e. Report recipient participation in order to analyze usage and develop more effective programs.

2. General Description

The Management and Administrative Reporting Subsystem presents a series of reports that are designed to meet the information requirements of those individuals responsible for control and operation of Title XIX Programs.

a. Approach

These information requirements have been classified into two categories:

- Functional Information Areas
- Reporting Levels.

Functional information areas including groupings of information corresponding to the data required to achieve or assist in accomplishing a given task. Functional requirements for information include four general areas:

- Administration
- Operations
- Provider Relations
- Recipient Relations.

The administration area includes those functions associated with overall management control, planning, and reporting. Typical functions include: policy planning and evaluation, fiscal planning and control, and Federal reporting.

While the operations functions may not be performed directly in the single State Agency organization, it is an essential area of management concern. This area involves the functions of claims receipt, review, adjudication and payment.

The Provider Relations functional area includes all activity associated with contact between the provider and the State Agency. Functions in this area include: enrollment and certification, surveillance and utilization review (S/UR), audit and cost settlement, evaluation, advisement, and education.

The fourth functional area, Recipient Relations, includes those activities related to the administration of the Medicaid Program with respect to recipients. Information requirements include: eligibility and identification, surveillance and utilization review, advisement, and education.

These functional areas have been established for reporting purposes in lieu of assuming a theoretical Medicaid organization. Section VII-B-2 (Page 15) discusses the considerations made in developing the subsystem design in this manner.

The second classification of information, Reporting Levels, is concerned with the grouping of information within each of the functional areas. These functional area groupings extend from summarized, concise data which reflects the status of the Title XIX Program at the highest reporting level to the multiplicity of detailed information at the lowest reporting level. Between these levels are two additional reporting levels of information which support supervisory and staff functions. To satisfy these varying degrees of information requirements the following reporting levels are defined:

Level One (Highest) - Status Reports: Concise summarization data which provides management with a composite overview of the current status of the Medicaid program.

Level Two - Summary Reports: Consolidated management information which expands upon Level One Reports and supports the functions of planning and evaluation of existing operations within each functional area.

Level Three - Analysis Reports and S/UR Profile Reports: Information which permits an in-depth review and analysis of a functional area in order to identify problems which may be present.

Level Four (Lowest) - Detail Reports: The lowest level of information distribution which contains the specific detailed information generated for use by a given functional area. These reports are generated within the other subsystems and are not included in MARS Reports in this section.

To support the information requirements at the various levels, this subsystem brings together key information from other subsystem files and summarizes this data into meaningful relationships. The other subsystems (Claims Processing, Provider, Recipient, and Surveillance and Utilization Review) have collected this data from sources external to the State Agency and have used the information to achieve the basic tasks required in day-to-day details of program administration. Since these subsystems have already captured the detailed information concerning vital program activity, it is only logical to bring it together in the Management and Administrative Reporting Subsystem in a summarized format in order that program management can determine the current status of the medical assistance program.

Data from the other subsystems is controlled and processed through five modules within the Management and Administrative Reporting Subsystem (MARS). Modules included in the subsystem are:

Control Module -- Reads the data files from other subsystems and computes summary information for use by other modules in the MARS Subsystem. This module also provides for the retention of claims processing, payment, provider and recipient participation history data.

Administrative Module -- Based on information supplied by the Control Module, prepares those reports required in the administration functional area.

Operations Module -- Produces the reports required in the operations functional area which monitor

claims adjudication and payment activity. Reports are produced based on data supplied by the Control Module.

Provider Relations Module -- Reports concerning the provider relations functional area are developed by this module.

Recipient Relations Module -- Functional information requirements required in the administration of recipient affairs are produced by this module based on data derived from the Control Module.

These modules may be combined during detail design to effect more efficient data processing methods. They do, however, serve meaningful data handling tasks since data must be extracted from other subsystem files, computations must be made, data relationships established and history data retained. In addition the subsystem modules transfer information into automated areas to establish relationships and compute report items.

The Management and Administrative Reporting Subsystem is designed to produce level one, two and three reports with the exception of S/UR management summaries. S/UR management summaries for level three will be produced by the S/UR Subsystem. All level four reports will be produced by the other subsystems in the normal process of data handling, and they will not be repeated in the MARS subsystem. Level one, two, and three management reports (except for data processing control reports) will be described in Section VII-D (Page 57) and will be discussed in Sections VII-C, E and F dealing with automated processing.

In summary the Management and Administrative Reporting Subsystem receives automated data from other model subsystems through the MARS Control Module. The MARS Control Module reads this data and computes the information required by the other four MARS modules. Each of these modules in turn utilizes Control Module data to prepare reports to support information requirements for the first three reporting levels in each functional area.

b. Subsystem Functions

The Management and Administrative Reporting Subsystem produces reports to support the Title XIX

Program staff in the performance of many administrative tasks. Some of these tasks and supporting subsystem functions include:

(1) Preparing budget allocations for various categories of service for the fiscal year.

(2) Projecting the cost of program services for future periods.

(3) Comparing current cost with previous period cost to establish a frame of reference for analyzing current expenditures.

(4) Comparing actual expenditures with budget to determine current and projected financial position.

(5) Analyzing the various areas of expenditure to determine the greatest areas of cost in comparison to the return in services.

(6) Reviewing the utilization of services by various recipient categories to determine the extent of participation and relative cost.

(7) Providing data essential to the development and formulation of program policies.

(8) Analyzing the break-even point between Medicare and Medicaid payments.

(9) Analyzing progress in accreting eligible Medicare Buy-In recipients.

(10) Reviewing provider participation with respect to number of recipients and analyzing the capacity of providers to handle projected service demands.

(11) Presenting claims processing and payment information to determine if providers are being reimbursed without unnecessary delay.

(12) Analyzing claims processing by categories of service to determine where the greatest areas of delay exist.

(13) Reviewing errors in claims processing to determine those errors most frequently committed by providers and claims processing personnel in order to improve training and forms.

(14) Developing third party payment profiles to determine where program cost reductions might be achieved.

(15) Assisting auditors in reviewing provider cost and establishing a basis for cost settlement.

(16) Establishing reasonable per diem rates and monitoring accumulated liability for deficit payments.

(17) Analyzing the timing of provider claim filing to insure good fiscal controls and statistical data.

(18) Monitoring individual provider payments to ensure reasonable fiscal procedures.

(19) Preparing and reviewing individual drug usage to reduce cost and avoid excessive use.

(20) Presenting geographic analysis of expenditures and recipient participation in order that social workers may determine areas of need.

(21) Providing information to support Federal reporting requirements.

These are but a few of the many functions performed and supported by the MARS Subsystem. The Information Flow Diagram, presented below, at the end of Section VII-A3 (Page111), shows the sources of information, automated processing, and all the reports encompassed by the MARS Subsystem. A review of the Information Flow Diagram, together with the functions listed above, will provide an overview of the subsystem and stimulate thought as to its capabilities.

c. Subsystem Processing Cycles

The subsystem modules will be processed monthly since no report is anticipated more frequently than monthly. There are monthly, quarterly and annual reports produced by the subsystem, however, these will be produced on the coinciding monthly cycle.

3. Information Flow Diagram

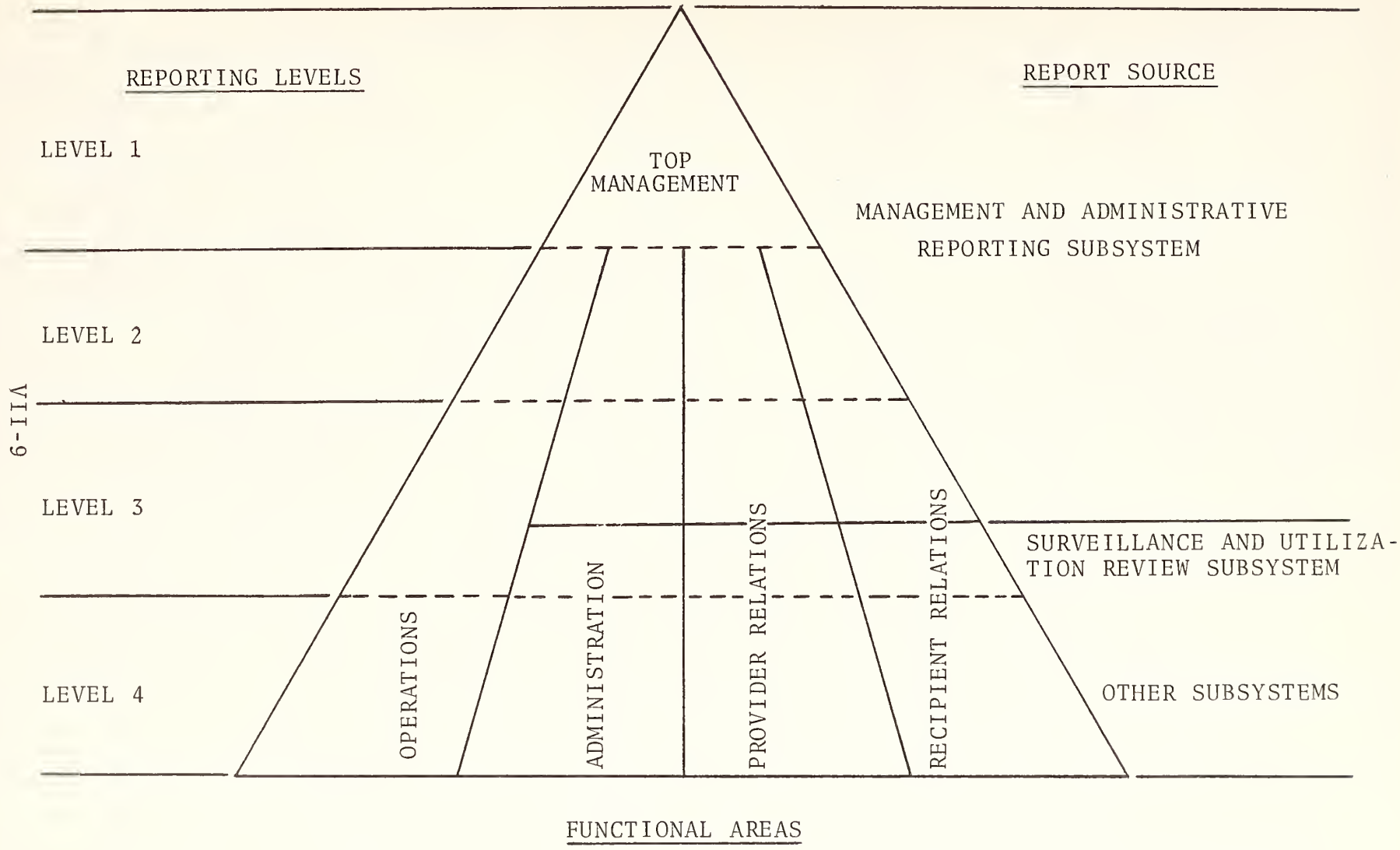
The Management and Administrative Reporting Subsystem Information Flow Diagram, found on the page VII-11, shows the interrelationships of the subsystem, the processing

modules, and identifies the primary users of each output. A description of the processing steps and flow of information within the modules is presented in detail in Section VII-C.

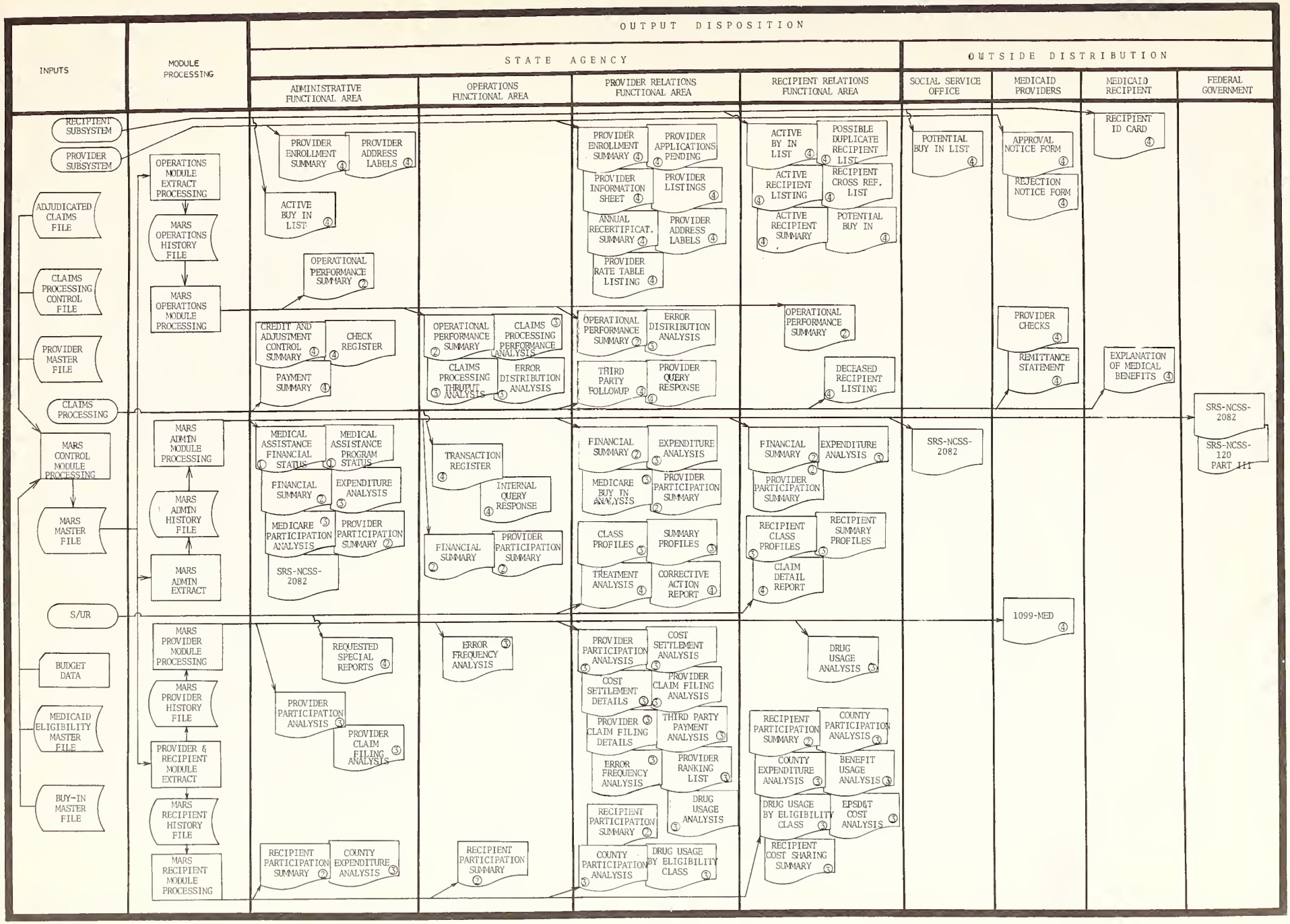
Even though level four reports are not defined in this section they are included in the Information Flow Diagram in order to show the relationship of all management reporting levels. The reporting level of each report is indicated on the Information Flow Diagram by a number in a circle adjacent to the report title.

The relationship between reporting levels and functional areas is pictorially presented in the chart, Management Reporting and Functional Area Relationships on the following page.

MANAGEMENT REPORTING AND FUNCTIONAL AREA RELATIONSHIPS



MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM INFORMATION FLOW DIAGRAM



B. DESIGN ELEMENTS

1. Constraints and Assumptions

The Management and Administrative Reporting Subsystem was designed based on the following constraints and assumptions:

a. With the exception of budget data all MARS information is derived from other subsystems in the model design. This subsystem is therefore constrained and limited by the availability, accuracy, and extent of data contained in the files defined in Section VII-E-1.

b. The Management and Administrative Reporting Subsystem assumes the development and operation of the Model Claims Processing, Provider, Recipient, and Surveillance and Utilization Review Subsystem or their equivalent.

c. Since the greatest percent of Title XIX programs are administered by organizations operating within a larger State agency it is, therefore, assumed that certain supporting administrative functions are performed by the larger agency. These functions include all accounting activity, personnel administration, payroll and timekeeping functions and a general management structure within which the Title XIX organization will perform. When higher levels of program management, or directors, are discussed it is assumed that the director of the larger State agency (State Department of Public Welfare, State Public Health Department, or similar agency) as well as the administrators of the Title XIX Program are included.

d. In conjunction with item C above, it is further assumed that the extent of the Management and Administrative Reporting Subystem will begin at a point after Medicaid eligibility has been established (by another agency, system or method) and will extend through the adjudication of claims, maintenance of provider relations, establishment and control of Title XIX policy, and the control of purely Title XIX fiscal planning and expenditures. The beginning point is defined by the eligibility data required to be transmitted to

the Title XIX agency to support the model Recipient Subsystem. The model system is also assumed to process all claims for Medical Assistance Payment (MAP) which are eligible for federal participation. The provisions for accreting individuals eligible for the Crippled Children Program and processing crippled children's claims is not specifically included in the scope of the model system. The Management and Administrative Reporting Subsystem, however, does not preclude addition of this function during detailed design.

e. The Management and Administrative Reporting Subsystem has been designed to require no more than the minimal computer configuration defined for the entire model system.

f. Effective fiscal control assumes current claims processing and payment subsystem operation.

g. It is assumed the Title XIX administrators are skilled in fiscal procedures and the State Agency is willing to effect fiscal control.

h. SRS Reports Bulletin, dated October 1973 establishes the "official SRS list of recurring reports". This bulletin indicates the following reports are applicable to Title XIX Agencies:

SRS-OA-25

SRS-OA-41

SRS-NCSS-2079.1

SRS-NCSS-2082.1

SRS-NCSS-120, Part III

Of these reports, SRS-NCSS-2082.1 and SRS-NCSS-120, Part III are fully supported by the model design. SRS-OA-25 and SRS-OA-41 require certain fiscal data not contained in the scope of the model design and should more practically be manually prepared. SRS-NCSS-120, Parts I and II contain required information which is supported by the model design, however, certain information concerning the form of vendor payments is not provided for in the scope of the model system.

SRS-NCSS-2079.1 requires data primarily associated with the disposition of Public Assistance

Applications which are not within the scope of the model design.

i. The primary objective of the Management and Administrative Reporting Subsystem, as previously stated, is to provide essential information to the administrators of Title XIX Programs. It is not necessary, however, that the Management and Administrative Reporting Subsystem produce all of this information from data contained in MARS Subsystem module files. While this was one of the approaches analyzed, it was considered impractical and not economical to duplicate the files of other subsystems solely for the purpose of developing reports. It is, however, the responsibility of the Management and Administrative Reporting Subsystem to determine that information requirements of all levels of management are satisfied. These requirements have been reviewed, and the reports produced by the Management and Administrative Reporting Subsystem, together with those produced by other subsystems in the Model Design, meet the minimal requirements of all reporting levels in each functional area.

j. Increased Federal concern with the EPSDT program under Title XIX was reflected in SRS issuance of a revised Program Regulation (Section 249.10). These regulations describe the need for a comprehensive EPSDT data base. The concept of individual case management lends itself to support of such a data base. However, it is important to recognize that the case management approach is dependent in part on the active participation of local welfare agencies, the function and operation of which are beyond the scope of the MMIS.

For this reason and also because further Federal reporting requirements concerning the EPSDT program are anticipated, the MARS approach to EPSDT is confined at this stage to statistical reporting. The reports developed will satisfy current Federal report requirements (SRS-NCSS-120, Part III) and, in addition, will furnish a comparison of those EPSDT program followup costs that can be identified from Medicaid claim data.

2. Design Considerations

Development of the Management and Administrative Reporting Subsystem required a number of design decisions to be made in areas where more than one approach was feasible. Each alternative was evaluated based on its

advantages and disadvantages prior to adoption of a particular solution or approach for the Management and Administrative Reporting Subsystem design. The following discussions summarize each major item of consideration, the alternatives explored and the resulting model system recommendation.

a. Design Approach

In developing an information system, such as the MARS Subsystem, the primary design emphasis is placed on determining what management information requirements exist. Once these requirements for information have been established the reporting methods are then formulated. Information requirements can be developed either by summarizing the information already captured in the system or by reviewing the manager's tasks and ensuring the system supports the information requirements. The latter approach has been taken in developing the MARS Subsystem. Consideration was given first to the functions to be performed and then to the relationship of functions to decision making processes and positions of responsibility. The resulting functions and responsibilities, inherent in each task, establish the requirements for information. Information requirements are defined in terms of specific reports and the supporting automated processing developed.

b. Functional Areas

The functional areas, defined in Section VII-A-2, are the result of various attempts to establish a typical Medicaid organization. Since the Model System must be designed to meet the reporting requirements of a variety of State organization structures, it seems impractical to theorize a hypothetical building block organization which would be analogous to each State's structure. There are, however, certain key functions which must be performed in order to effectively administer a Title XIX Program. These functions were identified, analyzed and grouped into the previously discussed four functional areas:

-- Administration

-- Operations

-- Provider Relations

-- Recipient Relations.

c. Reporting Levels

Management reporting levels are an extension of the definition of a working organization structure in that they are established to identify levels of responsibility and to determine the degree of data detail required at each level. These levels, once defined, preclude the necessity of referring to ambiguous organization titles such as Claims Department Manager, Medicaid Division Director, or Medicaid Audit Supervisor. These reporting levels, as previously defined, include:

Level One (Highest) - Status Reports: Concise summarization data which provides management with a composite overview of the current status of the Medicaid Program.

Level Two - Summary Reports: Consolidated management information which expands upon Level One Reports and supports the functions of planning and evaluation of existing operations within each functional area.

Level Three - Analysis Reports and S/UR Profile Reports: Information which permits an in-depth review and analysis of a functional area in order to identify problem areas that might be present.

Level Four (Lowest) - Detail Reports: The lowest level of information distribution which contains the specific detailed information generated for use by given functional area. These reports are generated within the other subsystems and are not included in MARS Reports in this section.

It must be recognized these are theoretical reporting levels and in actual practice may not be realistically applied to the functional areas in a rigid manner through an automated system. Some reporting levels may be more economically and practically developed through manual means, however, the method of preparation of a given report will be resolved during detail design. It should also be recognized that the levels of reporting do not necessarily require a separate report in each functional information area since one report may meet the requirements of two or more areas.

d. Reporting Cycles

While the objective of this subsystem is to provide management with essential information, it is not the objective to inundate management with excessive data. The reporting cycle has, therefore, been established as monthly for the shortest interval and progresses to quarterly and annual.

Certain reports, such as drug analysis and benfit usage reports, require the maintenance of data by individual recipient records. Because of this extensive volume of data that must be accumulated monthly by the MARS Control Module, the design has been developed to extract this information annually from the Adjudicated Claims File. Since the Adjudicated Claims File must retain this information for other purposes, this approach seems more practical and definitely more economical.

e. Design Details

This MARS Subsystem Outputs and Data File Sections (VII-D and VII-F) are concerned with the translations of data from other subsystem files through module processing and into report data items. The basic design question in this case becomes one of equating data used for computation to data appearing on the reports. Three terms have been used in defining this process: Data Elements, Work Items, and Report Items.

Data Elements are specific units of information having a unique meaning. Data Elements are used to identify units of information introduced into the system.

Work Items are units of information derived from one or more data element and do not necessarily appear on reports. Work Items are normally used internally in computer programs and are labels used to identify information for programming purposes.

Report Items are any unit of information or data appearing on an output report. Report Items represent data elements, work items or computations involving one or more work items.

In developing the Management and Administrative Reporting Subsystem general design, the data elements, work items and report items required in the subsystem have been defined in Sections VII-D, E and F. The relationships of data elements, work items, and report items and the methods of deriving one from the other have not been specifically defined since this is a detail design function.

3. Controls and Audit Trails

The Management and Administrative Reporting Subsystem is limited to those controls essential in good computer processing techniques since the prime source of information is from other subsystems within the model system. Controls will include:

a. Evaluating subsystem performance by balancing the totals generated by the preceding subsystem function.

b. Verifying the use of the most recent master file by checking file name, number and date generated.

c. Verifying input record and control totals against output records and control totals by accounting for computer generated and deleted records and totals.

d. Retaining master file controls and labels for input into the next processing module or cycle.

C. PROCESSING FLOW

1. Introduction

The Management and Administrative Reporting Subsystem receives its inputs from two sources: (1) Other Subsystem Output Files and (2) Manual Input. File Inputs from other subsystems include:

Adjudicated Claims File (CP-F-07)

Claims Processing Control File (CP-F-05)

Provider Master File (PS-F-01)

Buy-In Master File (RS-F-03)

Medicaid Eligibility Master File (RS-F-01)

The MARS Subsystem has only one manual input - Budget Data. This data is prepared by the agencies' fiscal planning section based on their knowledge of the changing financial picture and information provided in the MARS reports concerning actual and projected cost.

Data pertinent to management reports is extracted from the other subsystem files, combined with the manual input and used in computations and correlations to prepare the MARS Master File. The MARS Master File contains summarized data calculated from individual claims such as:

Total Claims Rejected This Month.

Total Payments for Physician Services to Old Age Recipients by County.

Total Expenditure for Inpatient Services by month for the last 13 months and the total expenditure for the last fiscal year.

Provider payments by month for the last fiscal year.

Number of Services rendered this month.

This type of data is retained on the MARS Master File and updated each month by the Control Module in order to maintain an accumulation of historical data on a central file.

The MARS Master File (MR-F-01) is utilized to update four other history files in the remaining subsystem modules. These files include:

Administrative History File (MR-F-02)

MARS Operations History File (MR-F-03)

MARS Provider History File (MR-F-04)

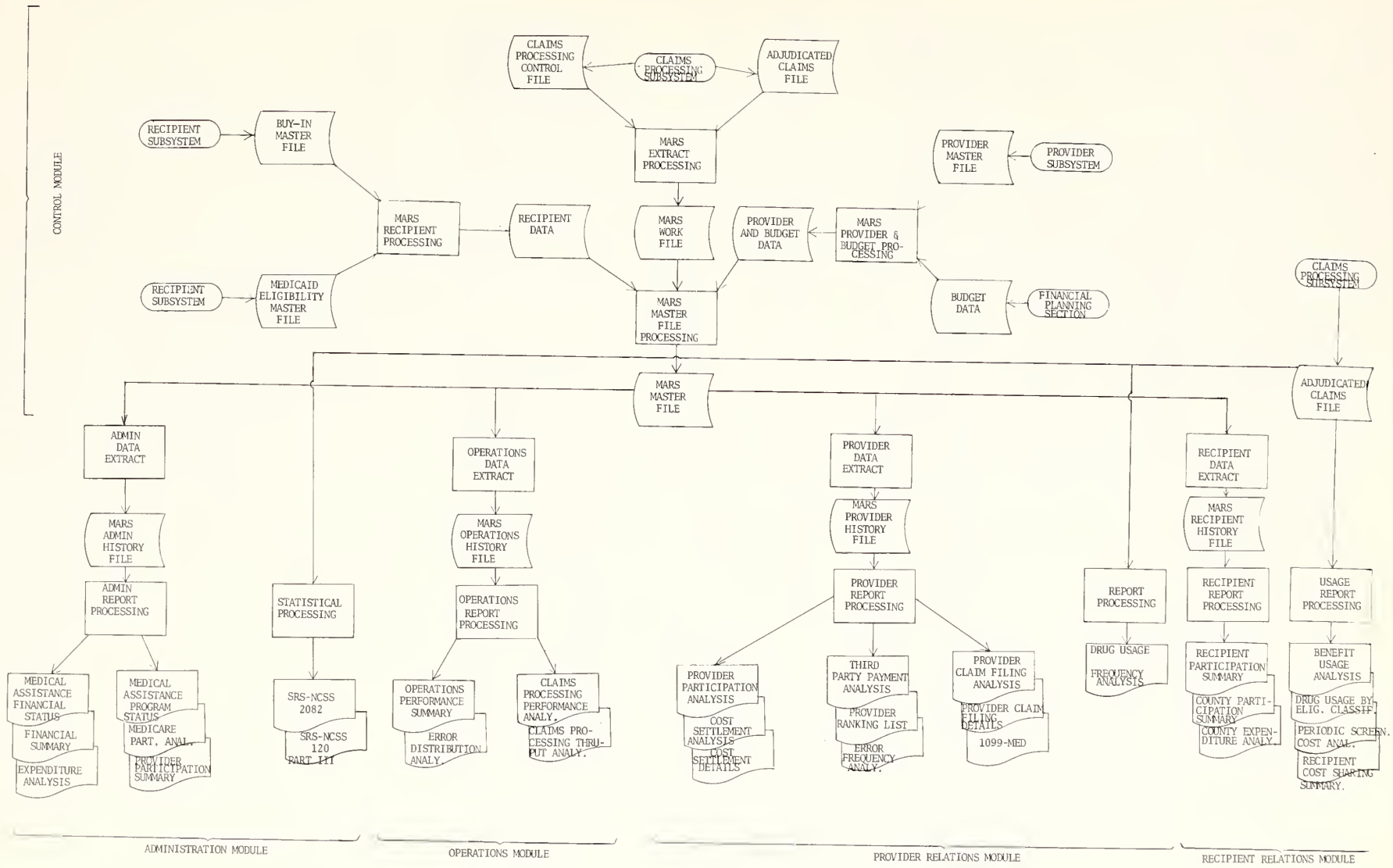
MARS Recipient History File (MR-F-05)

The four history files are utilized in the subsystem modules to prepare the functional area and level reports included in the Management and Administrative Reporting Subsystem.

2. Functional Flow Diagram

The Management and Administrative Reporting Subsystem Functional Flow Diagram found on the following page graphically depicts the processing flow described in the preceding section (VII-C-1).

Management and Administrative Reporting Subsystem Functional Flow Diagram



3. Module Description

The Management and Administrative Reporting Subsystem is comprised of the modules listed on this page. The remainder of this section is devoted to descriptions of these modules. Each module is described in turn in the following manner:

a. A brief description of major functions performed and outputs produced.

b. Processing Flowcharts.

c. Process Step Definitions, including special exhibits as required.

The Processing Flowchart provides a schematic of the processing flow within each module indicating each discrete processing step. Individual process steps are identified on the flowchart by a process step number of the form:

MX.YY

where M indicates the Management and Administrative Reporting Subsystem.

X indicates the module number.

YY indicates the number of a process step within that module.

Immediately following the Processing Flowcharts are descriptions of the activities or functions occurring at each process step within the module. These descriptions are presented on the Process Step Definition Sheet. The process step number provides a means of cross reference between the Processing Flowchart and the Process Step Definition Sheets.

Module Number	Module Name	Page Number
M1	Control Module	VII-26
M2	Administrative Module	VII-33
M3	Operations Module	VII-40
M4	Provider Module	VII-44
M5	Recipient Module	VII-50

VII. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

CONTROL MODULE

FUNCTIONS

The Control Module performs the primary functions of the Management and Administrative Reporting Subsystem. These functions include:

a. Extracting data required by the MARS Subsystem from the six MARS input files (Section VII-E).

b. Processing budget data.

c. Summarizing extracted data and making the necessary correlations and computations to support MARS Subsystem data requirements.

d. Performing MARS Master File maintenance and building a historic information base for use by the other MARS Subsystem Modules.

e. Purging the Claims Processing Control File of all claim records except those still in a state of suspension.

f. Resetting the error code and suspended code registers on all in-process claim records contained in the Claims Processing Control File.

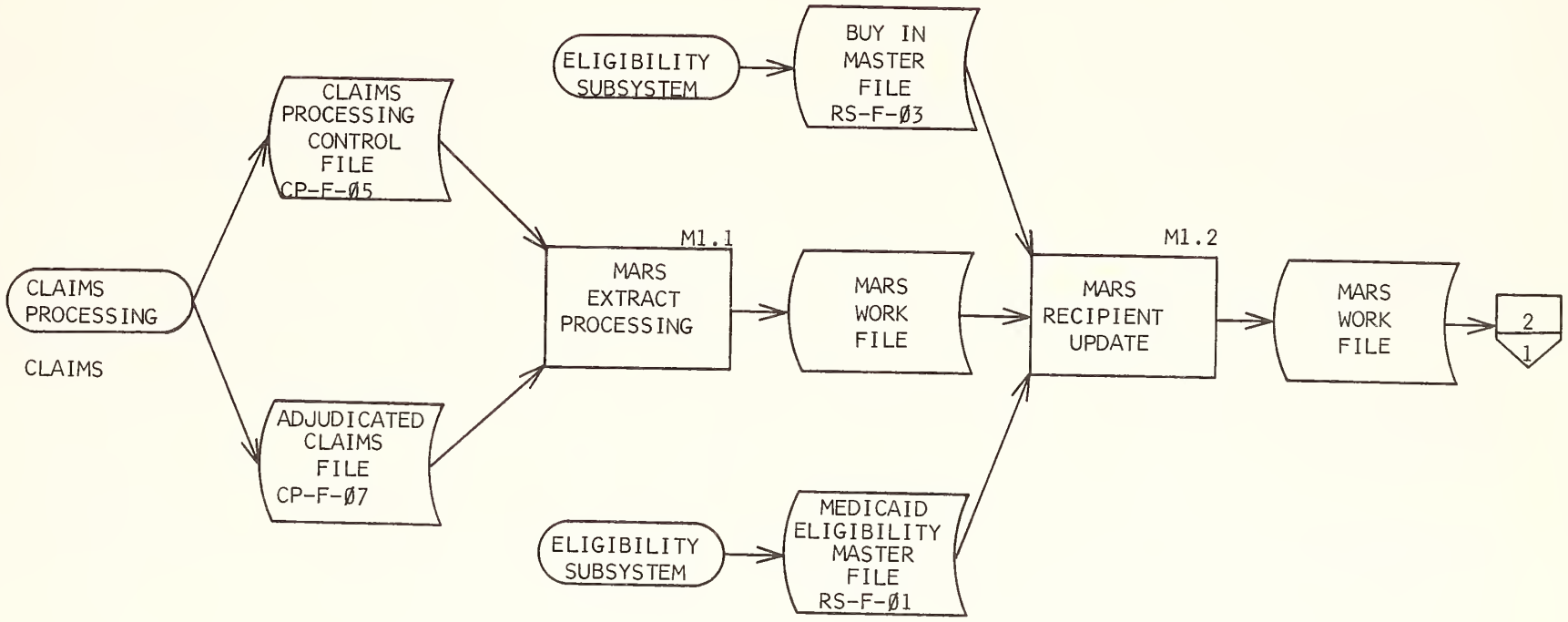
g. Maintaining unduplicated counts of recipients, providers, claims, payments and units of service.

OUTPUTS

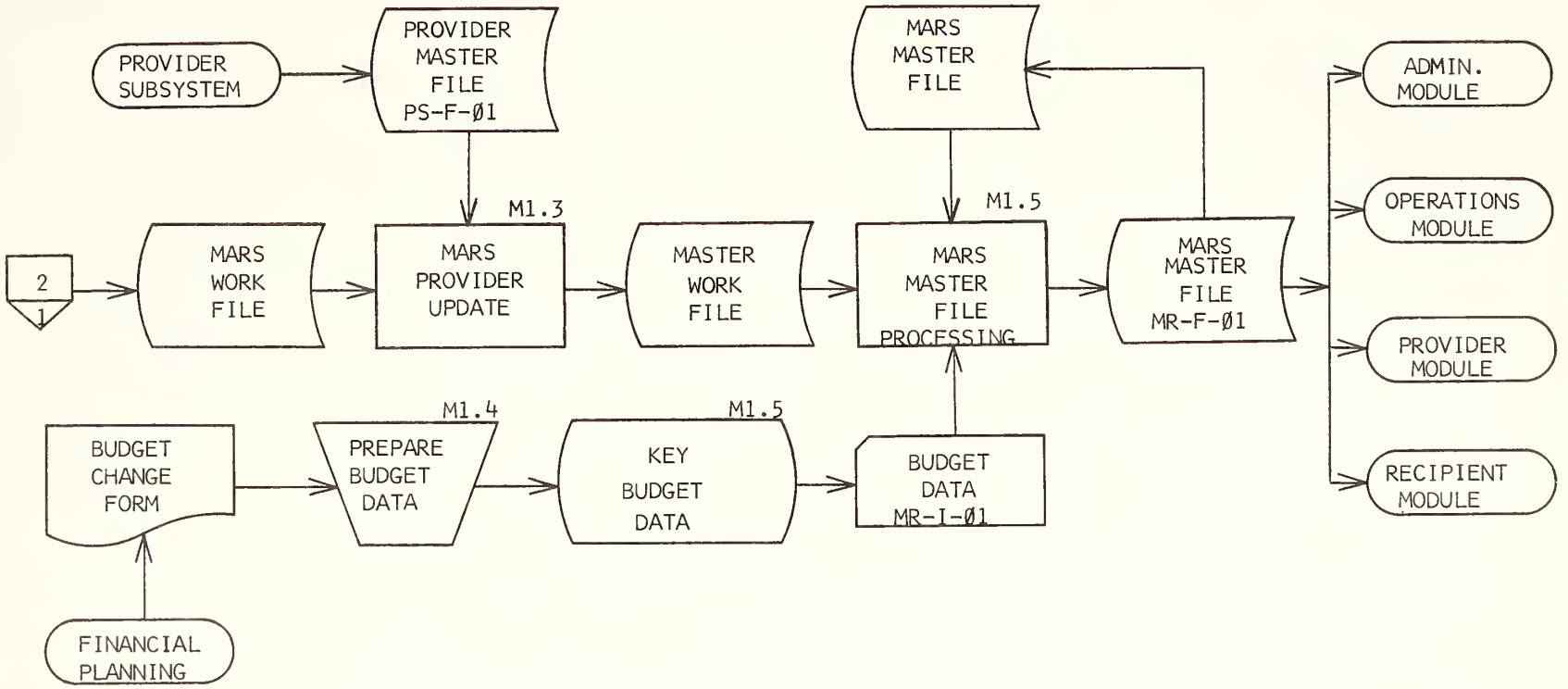
The MARS Control Module produces one major output:

MARS MASTER FILE (MR-F-Ø1).

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - CONTROL MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - CONTROL MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM MARS Control Module		
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
M1.1	Data Processing	Prepare a monthly MARS Work File from the Claims Process Control File and the Adjudicated Claims File records. Each record will be processed in order to extract and compute the basic claim information required to develop Management and Administrative reporting. As these files are read, the Suspense and Error counters will be reset to show the claim was suspended and reported in a prior month. Processing will also provide for building Recipient and Provider Number checks to enable an unduplicated participation count. This processing step will purge all Approved and Rejected Claims data from the Claims Processing Control File and extract data from the Adjudicated Claims File.
M1.2	Data Processing	The MARS Work File will be further updated with current month Recipient and Buy-In data. Buy-In premium, Aid Category and application data will be extracted.
M1.3	Data Processing	Provider enrollment and specific provider identification data will be extracted and added to the MARS Work File monthly.
M1.4	Medicaid Financial Planning	Develop and edit budget data by Category of Service for the current fiscal year.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM MARS Control Module		
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
M1.5	Data Processing	Receive Budget Data and key into machine readable form.
M1.6	Data Processing	Using last month's MARS Master File, prepare a Current Month MARS Master File which includes updated Budget Information. Based on the MARS Work File and last month's MARS Master File, compute current month and other time period statistical data retained by the Master File. The MARS Master File is further utilized by Additional Management and Administrative Reporting Subsystem Modules. The MARS Master File retains all history for 13 monthly periods and a total for the last fiscal year. This Processing Step includes interpretation of input file data into module file format.

VII. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

ADMINISTRATIVE MODULE

FUNCTIONS

The Administrative Module performs the following major functions:

a. Extracts data from the MARS Master File.

b. Prepares the MARS Administrative History File.

c. Correlates and computes information essential to preparation of module reports.

d. Formats and prints module reports.

e. Audits and verifies the accuracy of financial data computations.

OUTPUTS

The Administrative Module produces the following major outputs:

a. Medical Assistance Financial Status.

b. Medical Assistance Program Status.

c. Financial Summary.

d. Medicare Participation Analysis.

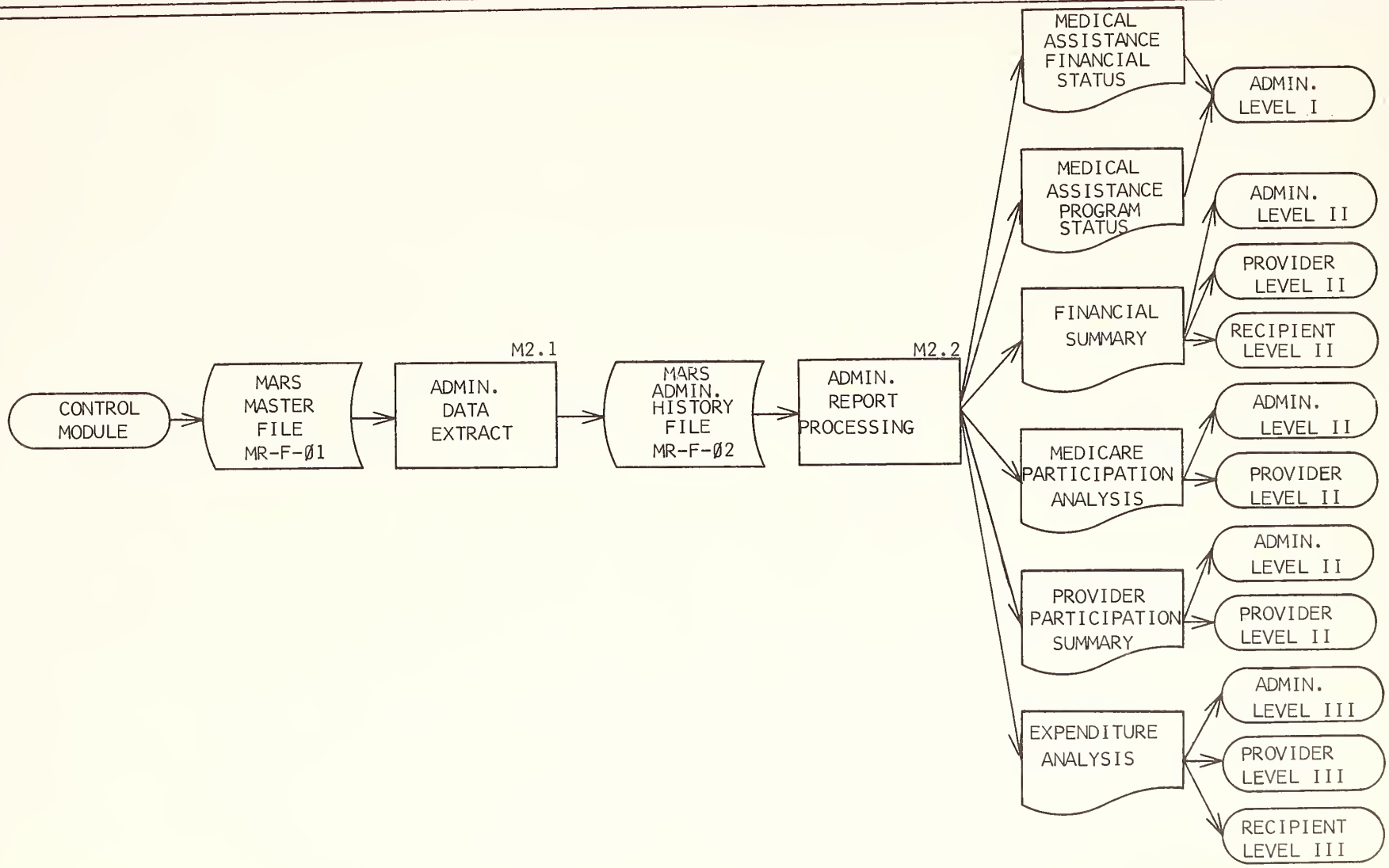
e. Provider Participation Summary.

f. Expenditure Analysis.

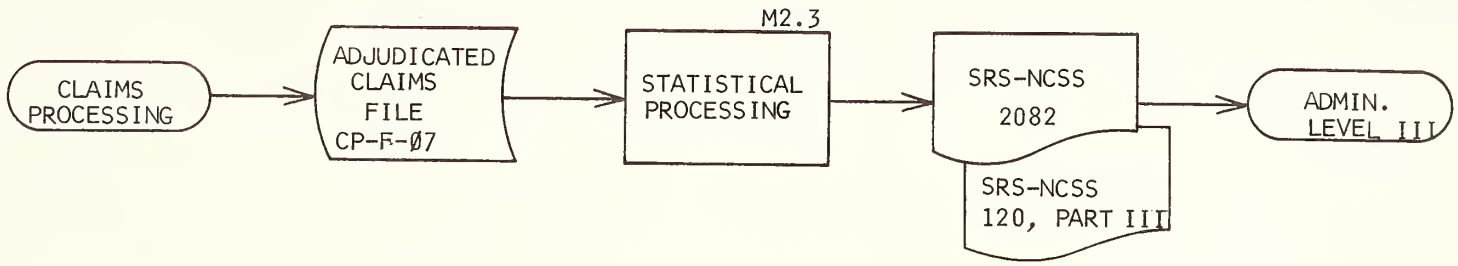
g. SRS-NCSS-2082.

h. SRS-NCSS-120, Part III.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - ADMINISTRATIVE MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - ADMINISTRATIVE MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	MARS Administrative Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
M2.1	Data Processing	Extract Administrative Reporting Data from the MARS Master File and prepare the MARS Administrative History File.
M2.2	Data Processing	Summarize and format the data contained in the Administrative Module Reports. Processing will be monthly and will produce monthly and quarterly reports.
M2.3	Data Processing	Annually read the Adjudicated Claims File extract and compute statistical data to support the Federal Reporting Requirement for SRS-NCSS- 2082 series and SRS-NCSS-120, Part III.

VII. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

OPERATIONS MODULE

FUNCTIONS

The Operations Module of the Management and Administrative Reporting Subsystem performs the following major functions:

a. Extracts Operations Module data from the MARS Master File.

b. Prepares the MARS Operations Master File.

c. Performs calculations and establishes the data relationships required by module reports.

d. Formats and produces the Operations Module reports.

OUTPUTS

The Operations Module produces the following major outputs:

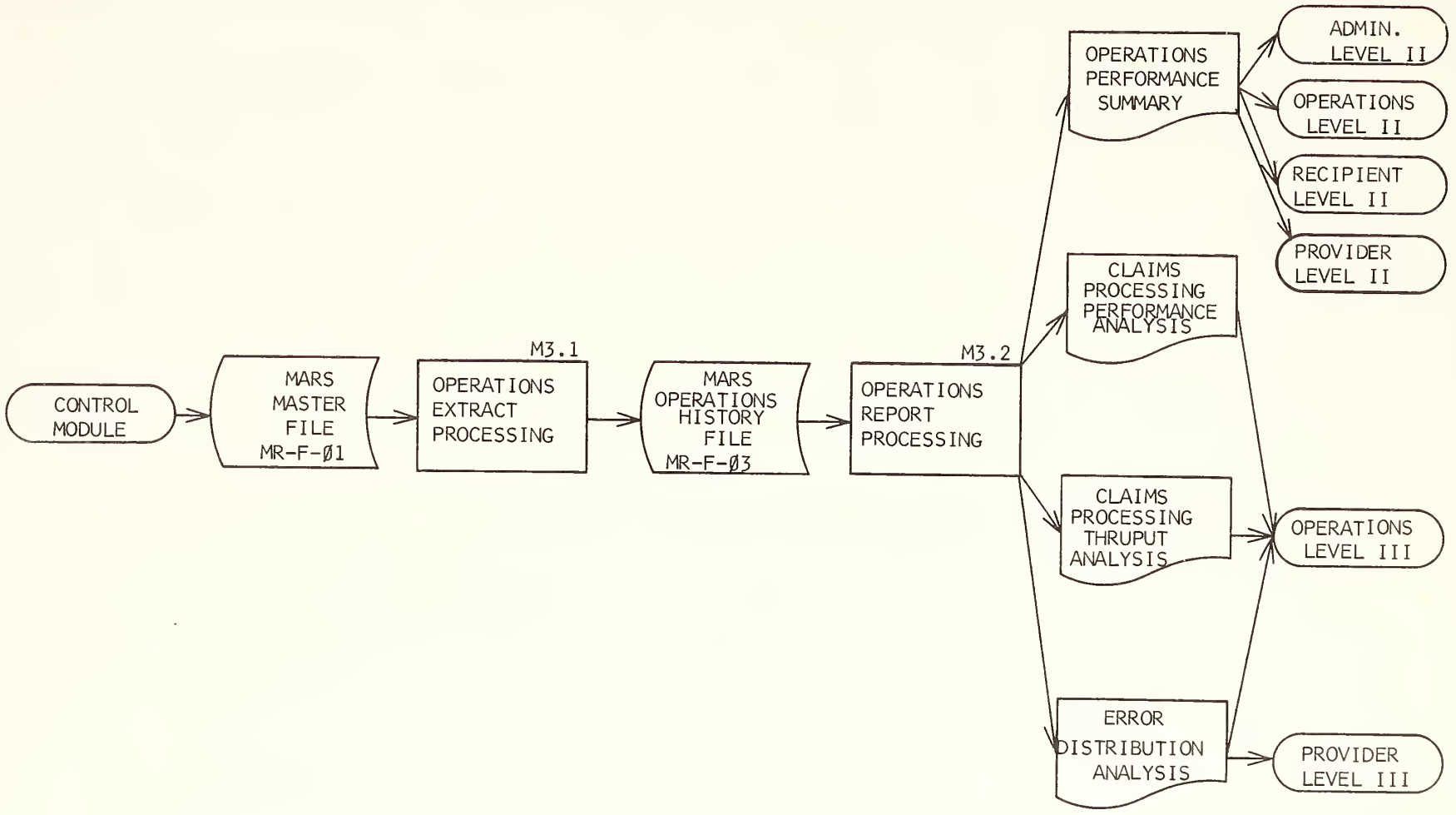
a. Operations Performance Summary.

b. Claims Processing Performance Analysis.

c. Claims Processing Thruput Analysis.

d. Error Distribution Analysis.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEMS - OPERATIONS MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM MARS Operations Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
M3.1	Data Processing	Read the MARS Master File, compute and format the MARS Operations History File.
M3.2	Data Processing	From the MARS Operations History File compute and write the monthly Operations Module reports.

VII. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

PROVIDER MODULE

FUNCTIONS

The Provider Module of the Management and Administrative Reporting Subsystem performs the following functions:

a. Reads the MARS Master File and extracts data required by the Provider Module.

b. Prepares the MARS Provider History File.

c. Performs the necessary calculations of totals, averages, trends and percentages required by module reports.

d. Formats and produces the module reports.

OUTPUTS

The Provider Module produces the following major outputs:

a. Provider Participation Analysis.

b. Provider Claim Filing Analysis.

c. Cost Settlement Analysis.

d. Cost Settlement Details.

e. Provider Claim Filing Details.

f. Provider Ranking List.

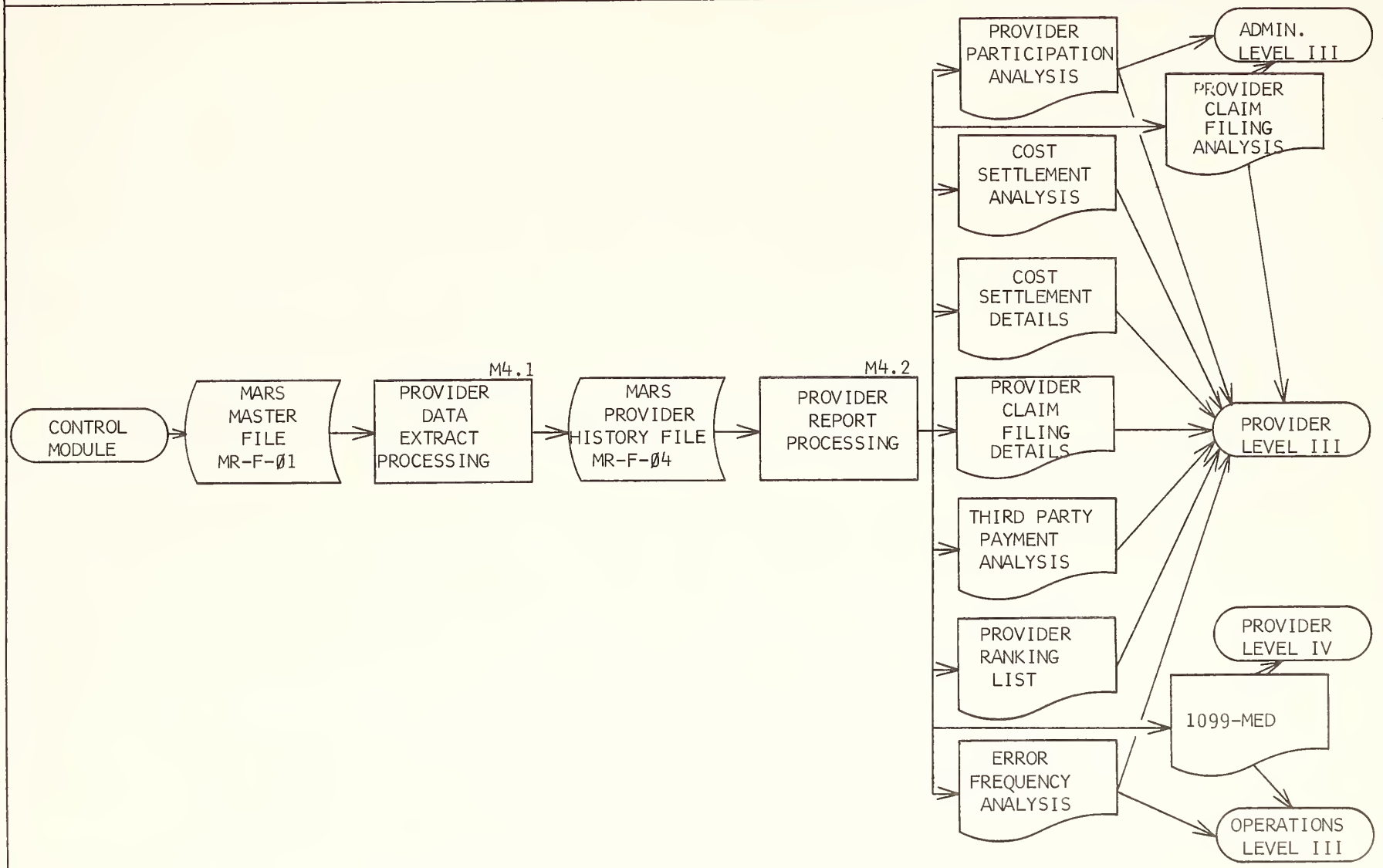
g. Third Party Payment Analysis.

h. 1099-MED.

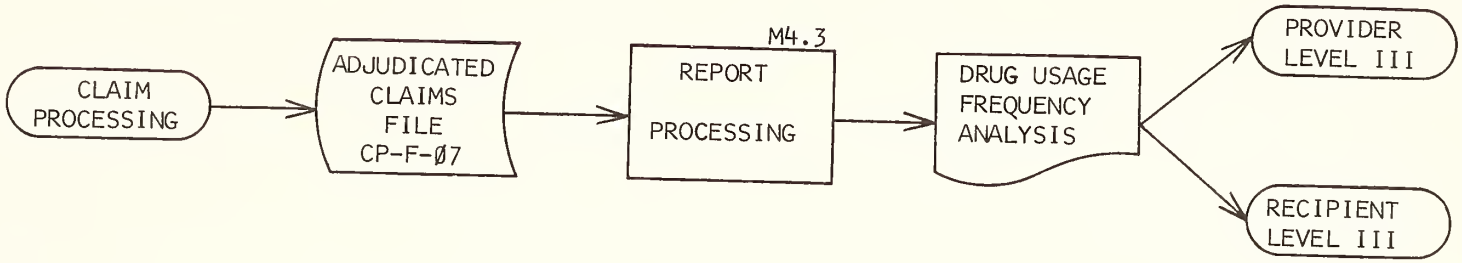
i. Error Frequency Analysis.

j. Drug Usage Frequency Analysis.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - PROVIDER MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - PROVIDER MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM MARS Provider Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
M4.1	Data Processing	Extract Provider statistical and claims data from the MARS Master File and write the MARS Provider History File.
M4.2	Data Processing	Summarize and format data from the MARS Provider History file to produce the Provider Relations Reports monthly. The 1099-MED Report will be prepared annually.
M4.3	Data Processing	Annually read the Adjudicated Claims File and extract data to produce the Drug Usage Frequency Analysis Report.

VII. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

RECIPIENT MODULE

FUNCTIONS

The Recipient Module of the Management and Administrative Reporting Subsystem performs the following major functions:

a. Extracts data from the MARS Master File.

b. Prepares the MARS Recipient History File.

c. Computes the data required by module reports.

d. Formats and produces module reports.

OUTPUTS

The Recipient Module produces the following primary outputs:

a. Recipient Participation Summary.

b. County Expenditure Analysis.

c. County Participation Analysis.

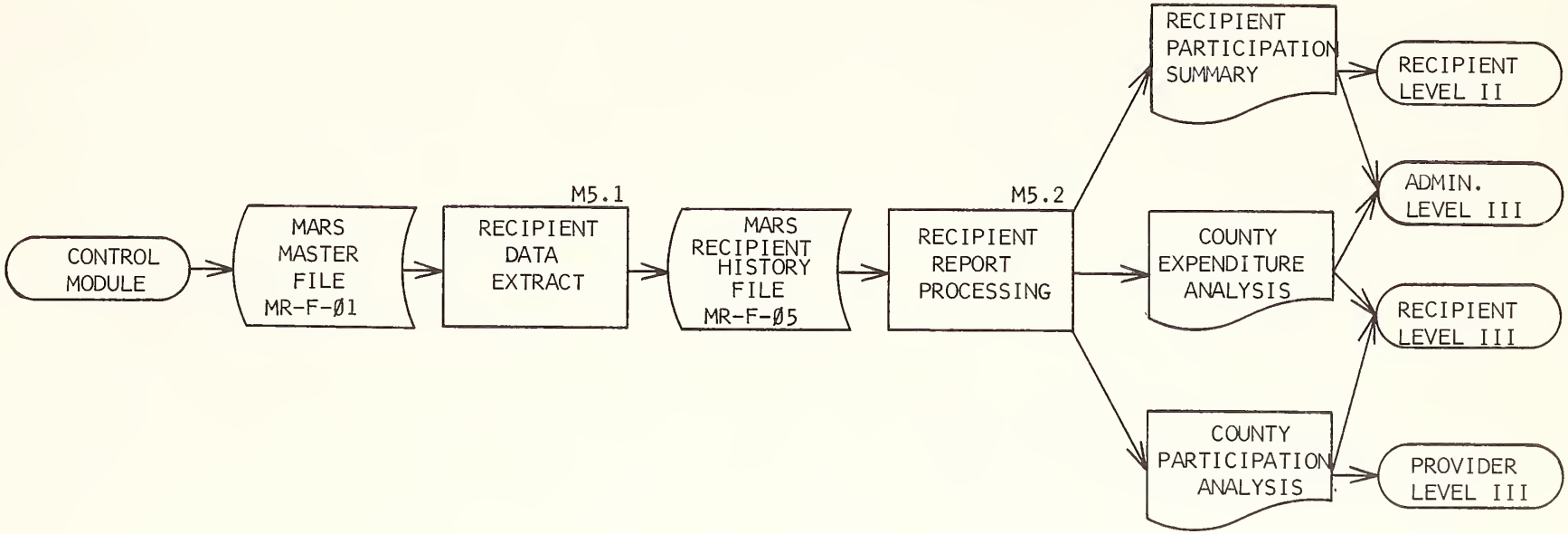
d. Benefit Usage Analysis.

e. Drug Usage by Eligibility Classification.

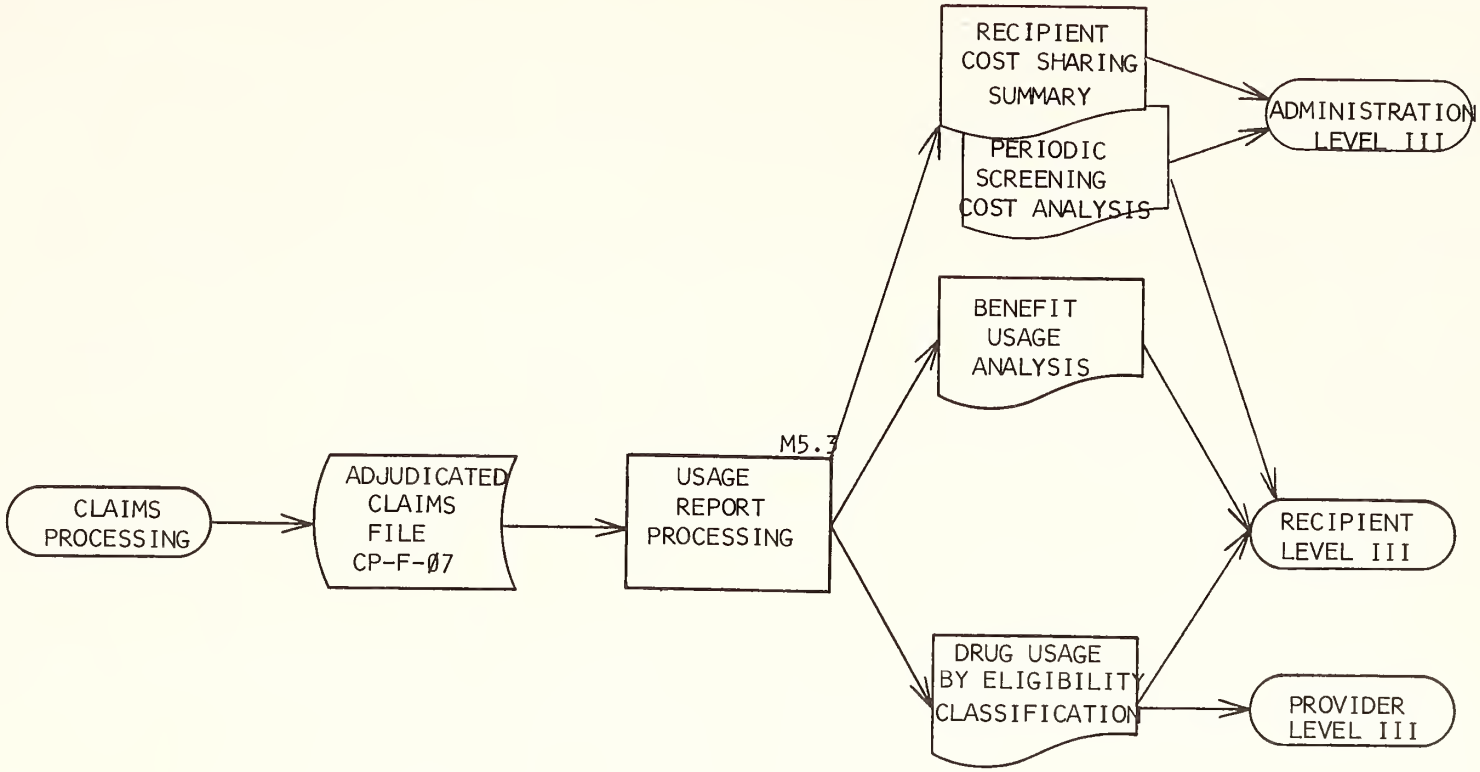
f. Periodic Screening Cost Analysis.

g. Recipient Cost Sharing Summary.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - RECIPIENT MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM - RECIPIENT MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM MARS Recipient Module		
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
M5.1	Data Processing	Extract Recipient History Data from the MARS Master File and write the MARS Recipient History File Monthly.
M5.2	Data Processing	Summarize and format the Recipient Relations reports from the MARS Recipient History File Monthly.
M5.3	Data Processing	Read the Adjudicated Claim File annually, extract and format data for the Benefit Usage Analysis, Drug Usage by Eligibility Classification, Periodic Screening Cost Analysis and Recipient Cost Sharing Summary Reports.

D. SUBSYSTEM OUTPUTS

The Management and Administrative Reporting Subsystem (MARS) is responsible for meeting the information requirements of all management reporting levels and all functional areas. To fulfill this responsibility the MARS outputs, which affect management and administrative activity, are listed in this section. The purpose, distribution, and sequence of each report is presented on an Output Definition Sheet. In most instances this sheet is followed by a sample report layout that depicts the general format and content of the report. The data displayed on the sample report format is entirely fictitious and is furnished solely to assist the reader in more readily gaining an understanding of the report.

The Report Item Description follows those reports produced by the Management and Administrative Reporting Subsystem. This sheet presents a definition of each report item listed on the preceding report, by number. These numbers are a cross reference to the numbers listed on the sample report format in an ellipse. These cross reference numbers are developed by using the report sequence number and then a report item sequence number within each report. For example, Report Item number 12.Ø5 refers to the fifth report item on report MR-O-12.

Information, contained in MARS reports, is presented in three primary sequences. These primary sequences are: Category of Service, Aid Category, and Time Period Order. Information on some reports may be displayed in two or more of these sequences.

Category of Service, as defined in Data Element Definition 301, includes twenty-three breakouts of service. This fine division of services is considered to be too detailed for management reporting purposes. The provision has been made however, to enable the various States to select the detail desired during the detail design phase. In the MARS Subsystem reports the Categories of Service have been consolidated for purposes of presenting sample report formats. The categories utilized are at the information level required by upper management, in monitoring the cost and effectiveness of the various Medicaid programs.

Aid Category, the second major sequence or arrangement of information, has also been combined in many cases from the definition established for Data Element 109. Again the

primary decision must be based on the level of detail required in each State's operations. The sample reports presented in the MARS Subsystem include representative Aid Categories which meet the planning requirements of program administrators.

Many of the sample reports presented in the MARS Subsystem include a sequencing of information by time periods. The objective has been to display fiscal and statistical information by pertinent time periods in order that a frame of reference be established to enable evaluation of current time period data. This frame of reference would enable administrators to determine program progress with respect to past performance as well as to projected future performance.

Level four reports, noted on the Information Flow Diagram (Section VII-A-3, page 11), are defined in the various subsystem descriptions. Further information on these reports can be obtained by referring to their respective subsystem section.

Surveillance and Utilization Review (S/UR) Management Summary Reports, are classed as level three reports and are of prime value and significance to the administrators of Title XIX Programs. For this reason these reports have been included in both the MARS and S/UR subsystem descriptions.

The Management Summary Reports correspond on a one for one basis to the Summary Profile Reports and the Treatment Analysis Reports. Whereas, the latter reports present data for individual Medicaid participants, the former present equivalent data for participant Class Groups and for Categories of Service. Management Summary Reports are intended to serve the following primary purposes:

a. Verify the statistical validity of each Class Group by use of standard deviations and frequency distributions.

b. Aid the Surveillance and Utilization Review Unit in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.

c. Provide management and administrative personnel with a detailed breakout of the overall utilization patterns of the various Medicaid services.

Management Summary Reports have the following characteristics:

a. Reports corresponding to Provider Summary Profile Reports are produced monthly, reports corresponding

to Treatment Analysis Reports and to Recipient Summary Profile Reports are produced quarterly.

b. Each report produced consists of three standard sections and one optional section for each Class Group.

c. The three standard sections present totals, averages, and standard deviations, for all Report Items defined for the Class Group or Category of Service concerned.

d. The optional section presents frequency distributions on all Report Items requested by the user. The class interval for each frequency distribution is also user specified.

e. The format of the Management Summary Reports is identical to that illustrated for the Summary Profile Reports.

The outputs contained in this section by Functional Area are indicated below. Those reports preceded by an asterisk (*) are produced by subsystems other than MARS. They are listed to indicate the functional relationship in each functional area. Reports preceded by an asterisk (*) are not defined in the MARS output descriptions which follow in this section.

Output Number	Output Name	Report Level	Page Number
ADMINISTRATIVE AREA			
MR-0-Ø1	Medical Assistance Financial Status	1	VII-65
MR-0-Ø2	Medical Assistance Program Status	1	VII-69
MR-0-Ø3	Financial Summary	2	VII-75
MR-0-Ø4	Expenditure Analysis	3	VII-79
MR-0-Ø5	Medicare Participation Analysis	3	VII-83
MR-0-Ø7	SRS-NCSS-2082	3	VII-87
MR-0-29	SRS-NCSS-120, Part III	3	VII-88.1
*RS-0-15	Active Buy-In List	4	II-101
*PS-0-12	Provider Enrollment Summary	4	III-82

Output Number	Output Name	Report Level	Page Number
*CP-0-Ø7	Credit and Adjustment Control Summary	4	IV-102
*CP-0-13	Check Register	4	IV-118
*CP-0-14	Payment Summary	4	IV-120
*SU-0-22	Requested Special Reports	4	VI-255
OPERATIONS AREA			
MR-0-Ø8	Operational Performance Summary	2	VII-89
MR-0-Ø9	Claims Processing Performance Analysis	3	VII-93
MR-0-1Ø	Claims Processing Thruput Analysis	3	VII-99
MR-0-11	Error Distribution Analysis	3	VII-103
*CP-0-Ø6	Transaction Register	4	IV-100
*CP-0-Ø8	Internal Query Response	4	IV-104
PROVIDER RELATIONS AREA			
MR-0-Ø6	Provider Participation Summary	2	VII-107
MR-0-12	Provider Participation Analysis	3	VII-111
MR-0-13	Cost Settlement Analysis	3	VII-115
MR-0-14	Cost Settlement Details	3	VII-119
MR-0-15	Provider Claim Filing Analysis	3	VII-123
MR-0-16	Provider Claim Filing Details	3	VII-127
MR-0-17	Third Party Payment Analysis	3	VII-131
MR-0-18	Error Frequency Analysis	3	VII-135
MR-0-19	Provider Ranking List	3	VII-139
MR-0-20	1099 - MED	3	VII-143

Output Number	Output Name	Report Level	Page Number
MR-0-21	Drug Usage Analysis	3	VII-147
*CP-0-Ø4	Third Party Followup Report	4	IV-96
*CP-0-Ø9	Provider Query Response	4	IV-106
*CP-0-11	Provider Checks	4	IV-110
*CP-0-12	Remittance Statement	4	IV-112
SU-0-Ø2	Physician Services Class Profiles	3	VII-151
SU-0-Ø3	Inpatient Hospital Services Class Profiles	3	VII-167
SU-0-Ø4	Outpatient Hospital Services Class Profiles	3	VII-173
SU-0-Ø5	Long Term Care Facility Services Class Profiles	3	VII-179
SU-0-Ø6	Dental Services Class Profiles	3	VII-185
SU-0-Ø7	Prescribed Drugs Class Profiles	3	VII-191
SU-0-Ø8	Other Provider Class Profiles	3	VII-197
SU-0-Ø9	Physician Treatment Analysis Class Profiles	3	VII-203
SU-0-10	Inpatient Hospital Treatment Analysis Class Profiles	3	VII-204
*SU-0-12	Physician Services Summary Profile Reports	3	VI-155
*SU-0-13	Inpatient Hospital Services Summary Profile Reports	3	VI-175
*SU-0-14	Outpatient Hospital Services Summary Profile Reports	3	VI-185
*SU-0-15	Long Term Care Facility Services Summary Profile Reports	3	VI-193
*SU-0-16	Dental Services Summary Profile Reports	3	VI-203

Output Number	Output Name	Report Level	Page Number
*SU-0-17	Prescribed Drugs Summary Profile Reports	3	VI-211
*SU-0-18	Other Provider Summary Profile Reports	3	VI-221
*SU-0-19	Physician Services Treatment Analysis Reports	4	VI-230
*SU-0-20	Inpatient Hospital Services Treatment Analysis Reports	4	VI-237
*SU-0-23	Correction Action Report	4	VI-257
*PS-0-Ø1	Approval Notice Form	4	III-58
*PS-0-Ø2	Rejection Notice Form	4	III-60
*PS-0-Ø5	Provider Applications Pending	4	III-66
*PS-0-Ø6	Provider Information Sheet	4	III-68
*PS-0-Ø8	Numeric Provider Listing	4	III-72
*PS-0-Ø9	Alphabetic Provider Listing	4	III-74
*PS-0-1Ø	Provider Listing By Type Provider	4	III-77
*PS-0-11	Provider Listing by Category of Service	4	III-80
*PS-0-13	Annual Recertification Summary	4	III-84
*PS-0-14	Provider Speciality Listing	4	III-86
*PS-0-15	Provider Listing By Group Affiliation	4	III-88
*PS-0-16	Provider Address Labels	4	III-90
*PS-0-17	Provider Rate Table Listing	4	III-92
RECIPIENT RELATIONS AREA			
MR-0-22	Recipient Participation Summary	2	VII-215

Output Number	Output Name	Report Level	Page Number
MR-0-23	County Participation Analysis	3	VII-219
MR-0-24	County Expenditure Analysis	3	VII-223
MR-0-25	Benefit Usage Analysis	3	VII-227
MR-0-26	Drug Usage by Eligibility Classification	3	VII-231
MR-0-27	Periodic Screening Cost Analysis	3	VII-234
MR-0-28	Recipient Cost Sharing Summary	3	VII-234.3
*RS-0-Ø3	Possible Duplicate Recipient List	4	II-76
*RS-0-Ø4	Recipient Identification Card	4	II-78
*RS-0-Ø7	Active Recipient Listing	4	II-84
*RS-0-Ø9	Recipient Cross Reference Listing	4	II-88
*RS-0-1Ø	Active Recipient Summary	4	II-90
*RS-0-12	Potential Buy-In List	4	II-94
*CP-0-Ø5	Deceased Recipient Listing	4	IV-98
*CP-0-15	Explanation of Medical Benefits	4	IV-122
SU-0-Ø1	Recipient Class Profiles	3	VII-235
*SU-0-11	Recipient Summary Profiles	3	VI-243
*SU-0-21	Claim Detail Report	4	VI-246

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Medical Assistance Financial Status	MR-0-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Administrative Module Process Step M2.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Program Management (Level I)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide a concise summary of the Medical Assistance Program's financial status. Financial data is presented by Category of Service for this month, and related time periods, to provide a frame of reference in evaluating expenditures and budgeted information.

REMARKS

This report is intended for use by the highest level of management. When combined with the Medical Assistance Program Status Report it provides a concise overview of Medicaid Program activities.

RUN DATE 6/30/72
MONTH OF JUNE

MEDICAL ASSISTANCE FINANCIAL STATUS

CATEGORY OF SERVICE	THIS MONTH BUDGET	THIS MONTH ACTUAL	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	FISCAL YEAR-TO-DATE BUDGET	FISCAL YEAR-TO-DATE ACTUAL	FISCAL YEAR-TO-DATE SAME MONTH LAST YEAR	FISCAL YEAR END PROJECTED BUDGET	FISCAL YEAR END PROJECTED COST	VARIANCE (OVER)/UNDER DOLLARS	VARIANCE (OVER)/UNDER PERCENT
INPATIENT SERVICES	1,380,000	1,387,237	1,228,979	1,568,237	11,316,000	13,996,693	13,256,110	17,250,000	19,412,996	(2,162,996)	(13%)
OUTPATIENT SERVICES	245,000	243,287	157,423	185,131	2,009,000	1,678,202	1,598,422	3,062,500	2,305,044	757,456	25%
NURSING HOME SERVICES	1,170,000	1,166,871	1,206,447	1,198,621	9,594,000	9,628,143	9,008,216	14,625,000	14,420,769	204,231	1%
PHYSICIAN SERVICES	840,000	845,623	776,000	874,187	6,888,000	7,387,160	6,845,579	10,500,000	10,263,017	236,983	2%
X-RAY AND LAB	1,000	929	462	1,249	8,200	12,891	12,896	12,500	16,558	(4,058)	(32%)
DRUGS	800,000	805,312	775,298	801,309	6,560,000	6,366,943	6,144,093	10,000,000	9,648,080	351,920	4%
DENTAL	80,000	110,863	94,600	132,961	656,000	1,123,042	894,631	1,000,000	1,615,222	(615,222)	(62%)
TOTALS	4,516,000	4,560,127	4,239,209	930,723	37,031,200	40,193,074	36,865,316	56,450,000	57,681,686	(1,231,686)	(2%)
	(1.01)	(1.02)	(1.03)	(1.04)	(1.05)	(1.06)	(1.07)	(1.08)	(1.09)	(1.10)	(1.11)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø1

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION		
SUBSYSTEM MARS Medical Assistance Financial Status			MR-O-Ø1	
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
1.01	Budget This Month	The amount budgeted for expenditure in the most recent month covered by the report.	X	
1.02	Expenditure This Month	The Medicaid payment for the most recent month covered by the report.	X	
1.03	Same Month Last Year	The Medicaid payment for the corresponding month in the previous fiscal year.	X	
1.04	Six Month Average This Year	The average monthly Medicaid payment for the most recent six months covered by the report.	X	
1.05	Fiscal Year To Date Budgeted Amount	The total of the monthly amounts budgeted for expenditure in the time period from the beginning of the fiscal year through the most recent month covered by the report.	X	
1.06	Fiscal Year To Date Expenditure Amount	The total Medicaid payments in the time period from the beginning of the fiscal year through the most recent month covered by the report.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Medical Assistance Financial Status	MR-O-Ø1

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
1.07	Fiscal Year To Date, Same Month Last Year	The total Medicaid payments in the time period from the beginning of the previous fiscal year through the month in the previous fiscal year that corresponds to the most recent month covered by the report.	X	
1.08	Fiscal Year Budgeted Amount	The total amount budgeted for expenditure in the current fiscal year.	X	
1.09	Fiscal Year Projected Cost	The total projected expenditure for the fiscal year. This projection is based on actual expenditures for the most recent twelve months using the least squares method.	X	
1.10	Variance Dollars	The dollar difference between the budgeted amount for the fiscal year and the projected total fiscal year expenditure. Projected costs in excess of their budgeted amount are shown in parentheses.	X	
1.11	Variance Percent	The variance amount as a percentage of the fiscal year budget amount (1.10 ÷ 1.08). If the projected costs exceed the budget, the variance percentage is enclosed in parentheses.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Medical Assistance Program Status	MR-0-Ø2
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Administrative Module Process Step M2.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Program Management (Level I)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Data	4.	
2.	Provider Data	5.	
3.	Claims Processing Data	6.	

PURPOSE OF OUTPUT

This report is designed to complement the Medical Assistance Financial Status Report to provide the highest level of management with concise, pertinent data which indicates the current status of Medicaid Program activity. Specific data is provided for the current month and related to previous time periods in order for management to obtain a frame of reference in drawing conclusions on program progress.

REMARKS

RUN DATE 6/30/72
MONTH OF JUNE

MEDICAL ASSISTANCE PROGRAM STATUS

		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	**** FISCAL YEAR-TO-DATE **** THIS YEAR	LAST YEAR
RECIPIENTS ****						
NUMBER OF RECIPIENTS ENROLLED	(2.01)	248,690	234,861	246,022	247,980	236,820
NUMBER OF RECIPIENTS RECEIVING SERVICE	(2.02)	104,101	97,846	101,560	227,339	218,430
PERCENT OF ENROLLED RECIPIENTS RECEIVING SERVICE	(2.03)	41.9 %	41.7 %	41.3 %	91.7 %	92.2 %
AVG. COST PER PARTICIPATING RECIPIENT	(2.04)	34.18	30.84	36.90	197.62	189.43
PROVIDERS ****						
NUMBER OF PROVIDERS ENROLLED	(2.05)	4,879	4,720	4,738	4,779	4,718
NUMBER OF PROVIDERS PARTICIPATING	(2.06)	2,730	2,432	2,489	4,262	3,901
PERCENT OF PROVIDERS PARTICIPATING	(2.07)	56.0 %	51.5 %	52.5 %	89.2 %	82.7 %
TOTAL SERVICE UNITS RENDERED	(2.08)	728,707	684,922	710,920	8,744,484	9,219,064
AVG. SERVICES PER PARTICIPATING PROVIDER	(2.09)	267	281	285	2,054	2,107
AVG. PAYMENT PER PARTICIPATING PROVIDER	(2.10)	1,228	1,241	1,506	10,541	10,607
CLAIM PROCESSING OPERATIONS ****						
TOTAL CLAIMS PROCESSED	(2.11)	343,940	320,428	342,890	4,127,280	3,845,136
PERCENT PAID	(2.12)	90.5 %	90.8 %	90.1 %	91.3 %	90.4 %
PERCENT REJECTED	(2.13)	5.2 %	6.1 %	5.6 %	5.8 %	5.3 %
CLAIMS IN PROCESS AT MONTH END	(2.14)	109,911	98,666	110,042	N/A	N/A
AVG. DAYS FROM CLAIM RECEIPT TO APPROVAL	(2.15)	22.7	24.3	21.9	21.2	21.3

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø2

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS Medical Assistance Program Status MR-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
2.01	Number of Recipients Enrolled	An unduplicated count of the number of recipients eligible for Medicaid benefits during the time period shown.	X	
2.02	Number of Recipients Receiving Service	An unduplicated count of the number of recipients receiving Medicaid benefits during the time period shown.	X	
2.03	Percent of Enrolled Recipients Receiving Service	The number of recipients receiving service divided by the number of recipients enrolled (2.02 ÷ 2.01 x 100).	X	
2.04	Average Cost Per Participating Recipient	The average Medicaid expenditure for recipients receiving Medicaid benefits.	X	
2.05	Number of Providers Enrolled	The number of providers that have agreed to participate in the Medicaid program or, if provider agreements are not required, the number of providers that have participated in the past.	X	
2.06	Number of Providers Participating	An unduplicated count of the number of providers that rendered services to Medicaid recipients in the time period shown.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Medical Assistance Program Status	MR-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
2.07	Percent of Providers Participating	The number of providers participating as a percent of the number of providers enrolled.	X
2.08	Total Service Units Rendered	The total units of service rendered by providers to Medicaid recipients.	
2.09	Average Services Per Participating Provider	The average number of service units provided by participating providers.	X
2.10	Average Payment Per Participating Provider	The average amount paid to participating providers for services rendered.	X
2.11	Total Claims Processed	The number of claims processed by the claims processing system. This count includes new claims received during the month plus prior claims recirculated through the system this month.	X
2.12	Percent Approved	The percentage of total claims processed approved for payment.	X
2.13	Percent Rejected	The percent of the total claims processed that were denied or returned to the provider for correction of errors.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Medical Assistance Program Status	MR-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
2.14	Claims In Process At Month End	The number of claims not yet adjudicated at the end of the month.	X	
2.15	Average Days From Entry Date To Approval	The average number of days between the date the claim is received by the State Agency and the date the claim is approved for payment.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Financial Summary	MR-0-Ø3
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Administrative Module Process Step M2.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Administration (Level II)
2.	Provider Relations (Level II)
3.	Recipient Relations (Level II)
4.	Operations (Level II)
5.	

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To present Medicaid financial data which will support evaluation of program status, measurement of progress, and aid financial and program planners. Budgeted and expenditure data for the current month are compared to related previous operating periods. Projection data for the remainder of the fiscal year is also presented. The report presents financial data by Category of Service and for the total program.

REMARKS

RUN DATE 6/30/72
MONTH OF JUNE

FINANCIAL SUMMARY

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	FISCAL YEAR-TO-DATE THIS YEAR	FISCAL YEAR-TO-DATE LAST YEAR	PROJECTED FISCAL YEAR END
PHYSICIAN SERVICES							
BUDGET	(3.01)	840,000	835,000	868,000	6,888,000	7,175,000	10,500,000
EXPENDITURE	(3.02)	845,623	776,000	874,187	7,387,160	6,845,579	10,263,017
VARIANCE: DOLLARS (OVER)/UNDER	(3.03)	(5,623)	59,000	(6,187)	(499,160)	329,421	236,983
PERCENT	(3.04)	(.7 %)	7.0 %	(.7 %)	(7.3 %)	4.6 %	2.3 %
ESTIMATED COST SETTLEMENT (DEFICIT)	(3.05)	NOT APPLICABLE FOR THIS SERVICE					
CLAIMS IN PROCESS (DOLLARS)	(3.06)	281,874	258,666	284,362	N/A	N/A	N/A
TOTAL FOR ALL CATEGORIES OF SERVICE							
BUDGET		4,516,000	4,608,000	4,600,000	37,031,200	37,785,600	56,450,000
EXPENDITURE		4,560,127	4,239,209	4,700,000	40,193,074	36,865,316	57,681,686
VARIANCE: DOLLARS (OVER)/UNDER		(44,127)	368,796	(100,000)	(3,161,874)	920,284	(1,231,686)
PERCENT		(1.0 %)	8.0 %	(2.2 %)	(8.5 %)	2.4 %	(2.2 %)
ESTIMATED COST SETTLEMENT (DEFICIT)		(22,800)	21,196	N/A	N/A	N/A	N/A
CLAIMS IN PROCESS (DOLLARS)		1,520,042	1,413,069	1,520,302	N/A	N/A	N/A

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø3

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Financial Summary	MR-O-Ø3

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
3.01	Budget	The amount budgeted for expenditure in the time periods shown.	X	
3.02	Expenditure	The actual Medicaid payment in the time periods shown. The amount shown under "Projected Fiscal Year End" is projected from the most recent twelve month's actual expenditures using the least squares method.	X	
3.03	Variance Dollars	The dollar difference between the budgeted amount and the actual or projected expenditures (3.01 - 3.02). Actual or projected costs in excess of their budgeted amounts are enclosed in parentheses.	X	
3.04	Variance Percent	The variance amount as a percentage of the budgeted amount. If the actual or projected expenditures exceed the budgeted amount, the variance percentage is enclosed in parentheses.	X	
3.05	Estimated Cost Settlement	The difference in the interim payments to cost settled providers and the estimated total of actual provider costs. This amount should equal the total of report item 13.08 on the Cost Settlement Analysis (MR-O-13).	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Financial Summary	MR-O-Ø3

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
3.06	Claims In Process (Dollars)	The total of all charges shown on claims in the suspense file at month end. The Six Month Average This Year contains the average month end value of claims for the most recent six months.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Expenditure Analysis	MR-0-Ø4
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Administrative Module Process Step M2.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1. Administration (Level III)
2. Provider Relations (Level III)
3. Recipient Relations (Level III)
4.
5.

SEQUENCE

1.	Category of Service	4.	
2.	Aid Category	5.	
3.		6.	

PURPOSE OF OUTPUT

The report is intended to provide an analysis of expenditure data to support financial planning and policy development. The report presents expenditure data by Aid Category within Category of Service and states the current trend of expenditures. Areas of greatest current and anticipated expenditure may be analyzed with respect to utilization of services.

REMARKS

RUN DATE 6/30/72

MONTH OF JUNE

EXPENDITURE ANALYSIS

CATEGORY OF SERVICE: PHYSICIAN SERVICES

	PAYMENTS TOTAL	PAYMENTS TREND	UNITS OF SERVICE RENDERED TOTAL	UNITS OF SERVICE RENDERED TREND	SERVICE UNITS PER ELIGIBLE RECIPIENTS AVERAGE	SERVICE UNITS PER ELIGIBLE RECIPIENTS TREND	AVERAGE COST PER ELIGIBLE RECIPIENT AVERAGE	AVERAGE COST PER ELIGIBLE RECIPIENT TREND
CATEGORIALLY NEEDY (MONEY PAYMENT)								
AGED	246,684	+.010	25,160	+.002	.571	+.003	5.60	+.010
BLIND	10,130	+.015	1,356	+.001	1.306	+.001	9.76	+.015
DISABLED	157,024	+.011	25,977	+.001	1.497	+.002	9.05	+.011
AFDC CHILDREN	91,175	+.010	15,056	+.001	.623	+.002	3.77	+.010
AFDC ADULTS	1,519	+.012	271	+.001	1.514	+.002	8.49	+.012
TOTAL	506,532		67,820		.781		5.84	
CATEGORICALLY NEEDY (NO MONEY PAYMENT)								
AGED	147,433	+.010	10,915	+.002	.623	+.003	73.86	+.013
BLIND	156	+.015	42	+.001	1.518	+.001	39.00	+.012
DISABLED	17,184	+.011	3,094	+.001	1.614	+.002	80.68	+.011
AFDC CHILDREN	14,993	+.010	2,676	+.001	1.738	+.002	9.74	+.010
AFDC ADULTS	132,440	+.012	23,756	+.001	1.765	+.002	9.84	+.013
OTHER XIX CHILDREN UNDER 21	154	+.015	40	+.002	.482	+.001	1.86	+.019
TOTAL	312,360		41,821		2.419		18.06	
MEDICALLY NEEDY								
AGED	11,582	+.035	925	+.002	1.071	+.003	6.45	+.038
BLIND	510	+.010	91	+.001	2.106	+.002	10.61	+.013
DISABLED	811	+.042	145	+.001	2.247	+.001	9.95	+.048
AFDC-RELATED CHILDREN	6,211	+.050	1,114	+.001	1.475	+.002	4.50	+.054
AFDC-RELATED ADULTS	5,612	+.017	1,007	+.001	2.504	+.002	9.02	+.021
OTHER XIX CHILDREN UNDER 21	385	+.038	69	+.001	.950	+.001	2.58	+.041
OTHER XIX ADULTS 21-64	215	+.051	39	+.001	2.502	+.002	10.63	+.058
TOTAL	25,326		3,390		1.775		6.83	
TOTAL XIX RECIPIENTS	844,218		113,031		2.819		8.72	
OTHER RECIPIENTS								
	(4.01)	(4.02)	(4.03)		(4.04)		(4.05)	

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø4

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Expenditure Analysis	MR-O-Ø4

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
4.01	Total Payments	The total dollar expenditure for services rendered by providers in the category of service and the aid category indicated.	X
4.02	Trend	A measure of the rate at which the magnitude of the data is changing. Trends will be calculated by the least squares method based on the past twelve months of data.	X
4.03	Total Units of Service Rendered	The total units of service rendered by providers in the category of service indicated to Medicaid recipients in the aid category indicated.	X
4.04	Average Service Units Per Eligible Recipient	The total units of service received in this category divided by the total number of eligible recipients.	X
4.05	Average Cost Per Eligible Recipient	Total Medicaid expenditures in this category of service divided by the total number of eligible recipients.	X

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Medicare Participation Analysis	MR-0-Ø5
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Administrative Module Process Step M2.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Administration (Level II)
2.	Provider Relations (Level II)
3.	
4.	
5.	

SEQUENCE

1.	Report Item	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide planning and control information with respect to the Buy-In program. Recipient eligibility and accretion data are presented by time periods to enable analysis of the progress made in certifying those individuals eligible for Medicare.

REMARKS

RUN DATE 6/30/72
MONTH OF JUNE

M E D I C A R E P A R T I C I P A T I O N A N A L Y S I S

		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	***** FISCAL YEAR-TO-DATE **** THIS YEAR	LAST YEAR
TOTAL RECIPIENTS AGED, BLIND & DISABLED	5.01	80,393	75,242	79,032	N/A	N/A
PART A						
RECIPIENTS NOT ELIGIBLE FOR PART A	5.02	42	80	28	N/A	N/A
NUMBER CLAIMS RECEIVED	5.03	2,868	2,799	2,805	33,675	33,008
PAYMENTS PENDING	5.04	22,980	21,868	23,042	N/A	N/A
TOTAL MEDICAID PAYMENTS FOR PART A DEDUCTIBLE AND COINSURANCE	5.05	128,505	129,450	130,960	1,443,682	1,338,493
TOTAL MEDICARE PART A PAYMENTS FOR CROSSOVER CLAIMS	5.06	414,020	375,920	401,610	4,948,622	4,411,623
MEDICAID EXPENDITURES AS A PERCENT OF TOTAL PAYMENTS MADE FOR MEDICAID-MEDICARE ELIGIBLES	5.07	23.7 %	25.6 %	24.6 %	22.6 %	23.3 %
PART B						
RECIPIENTS BOUGHT IN	5.08	80,059	73,444	80,002	N/A	N/A
RECIPIENTS ELIGIBLE BUT NOT ACCRETED	5.09	292	96	131	N/A	N/A
TOTAL BUY-IN PREMIUM	5.10	450,200	381,908	448,011	5,376,132	4,548,380
NUMBER CLAIMS RECEIVED	5.11	23,099	22,102	23,610	23,420	22,842
PAYMENTS PENDING	5.12	49,687	62,483	54,833	N/A	N/A

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø5

MEDICARE PARTICIPATION ANALYSIS

		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG THIS YEAR	***** FISCAL YEAR-TO-DATE ***** THIS YEAR	LAST YEAR
PART B (CONTINUED)						
TOTAL MEDICAID PAYMENTS FOR PART B DEDUCTIBLE AND COINSURANCE	(5.13)	276,985	222,364	273,622	3,321,820	2,668,368
TOTAL MEDICARE PART B PAYMENTS FOR CROSSOVER CLAIMS	(5.14)	1,163,337	1,022,338	1,174,823	12,960,044	11,268,044
TOTAL MEDICAID PAYMENTS (BUY-IN, DEDUCTIBLES AND COINSURANCE) AS A % OF TOTAL MEDICARE AND MEDICAID PAYMENTS ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES	(5.15)	38.5 %	37.1 %	38.1 %	40.2 %	39.0 %
BUY-IN PREMIUM AS A PERCENT OF MEDICARE PART B PAYMENTS	(5.16)	38.7 %	37.4 %	38.1 %	41.5 %	40.4 %
PARTS A AND B						
TOTAL MEDICAID EXPENDITURES FOR MEDICAID-MEDICARE ELIGIBLES (BUY-IN, DED., AND COINS.)	(5.17)	885,690	733,722	852,593	10,141,638	8,555,241
TOTAL PAYMENTS BY MEDICARE AND MEDICAID ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES	(5.18)	2,443,047	2,131,980	2,429,026	28,050,304	24,234,908
TOTAL MEDICAID EXPENDITURES FOR MEDICAID-MEDICARE ELIGIBLES AS A PERCENT OF TOTAL PAYMENTS ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES	(5.19)	35.0 %	34.4 %	35.1 %	36.2 %	35.3 %

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø5

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM	MARS Medicare Participation Analysis	MR-O-Ø5	
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED / MINIMAL
5.01	Total Recipients Aged, Blind and Disabled	A count of Medicaid recipients eligible for Medicare.	X
5.02	Recipients Not Eligible for Part A	A count of Medicaid recipients over sixty-five that do not qualify for Medicare.	X
5.03	Number Claims Received	The number of Medicare Part A claims received by Medicaid for payment of the Medicare deductible and coinsurance for those Medicaid recipients eligible for Medicare.	X
5.04	Payments Pending	The total amount of the deductible and coinsurance on Medicare Part A claims that have been received but not adjudicated.	X
5.05	Total Medicaid Payments for Part A Deductible and Coinsurance	The total payment for Medicare Part A services made by Medicaid for Medicaid-Medicare eligibles.	X
5.06	Total Medicare Part A Payments for Crossover Claims	The amount paid by Medicare for Part A services rendered to Medicaid-Medicare eligibles.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Medicare Participation Analysis	MR-O-Ø5

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
5.07	Medicaid Expenditures As A Percent Of Total Payments Made For Medicaid-Medicare Eligibles	The percent of the expenditures by Medicaid and Medicare for Part A services to Medicaid-Medicare eligibles that Medicaid paid.	X
5.08	Recipients Bought In	The number of Medicaid recipients whose Medicare Part B premium is paid by Medicaid.	X
5.09	Recipients Eligible But Not Accreted	The number of Medicaid recipients that are sixty-five or older and have not been accepted as eligible for Part B coverage by Medicare.	X
5.10	Total Buy In Premium	The total premium paid by Medicaid to Medicare for recipients bought in.	X
5.11	Number Claims Received	The number of Medicare Part B claims received by Medicaid for payment of the Medicare deductible and coinsurance for those Medicaid recipients eligible for Medicare.	X
5.12	Payments Pending	The total amount of the deductible and coinsurance on Medicare Part B claims that have been received but not adjudicated.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION		
SUBSYSTEM MARS Medicare Participation Analysis			MR-O-Ø5	
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
5.13	Total Medicaid Payments for Part B Deductible and Coinsurance	The total payment for Medicare Part B services made by Medicaid for Medicaid-Medicare eligibles.	X	
5.14	Total Medicaid Part B Payments for Crossover Claims	The amount paid by Medicare for Part B services rendered to Medicaid-Medicare eligibles.	X	
5.15	Total Medicaid Payments (Buy In, Deductibles and Coinsurance) as a Percent of Total Medicare and Medicaid Payments on Behalf of Medicaid-Medicare Eligibles	The sum of items 5.10 and 5.13 divided by the sum of items 5.10, 5.13 and 5.14 and multiplied by 100.	X	
5.16	Buy In Premium as a Percent of Medicare Part B Payments	Item 5.10 divided by item 5.14 and multiplied by 100.	X	
5.17	Total Medicaid Expenditures for Medicaid-Medicare Eligibles (Buy In, Deductible, and Coinsurance)	The sum of items 5.05, 5.10 and 5.13.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS Medicare Participation Analysis MR-0-Ø5

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
5.18	Total Payments by Medicare and Medicaid on Behalf of Medicaid-Medicare Eligibles	The sum of items 5.05, 5.06, 5.10, 5.13 and 5.14.	X	
5.19	Total Medicaid Expenditures for Medicaid-Medicare Eligibles as a Percent of Total Payments on Behalf of Medicaid-Medicare Eligibles	Item 5.17 divided by item 5.18 multiplied by 100.	X	

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
SRS-NCSS 2082	MR-O-Ø7
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Administrative Module Process Step M2.3	Annual
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Administration (Level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.		4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide data essential to the preparation of Federal Reports. The reports present Medicaid expenditures and recipient counts by various statistical and demographic groupings on an annual basis.

REMARKS

Federal Report SRS-NCSS 2082 report format is specified on National Center for Social Statistics form OMB No. 83-R0206

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM MARS SRS-NCSS-2082			MR-O-Ø7
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED / MINIMAL
		The report format and report items for this output are specified by the National Center for Social Statistics on Form OMB No. 83-RO-206. All report items can be supported by the Model System design.	

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
SRS-NCSS-120, Part III	MR-O-29
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Administrative Module Process Step M2.3	Annually
	MEDIA
	Paper

DISTRIBUTION

1.	Administration (Level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.		4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide data essential to the preparation of Federal Reports. Part III of the report presents numbers of individuals screened (with various problems) and numbers referred for treatment.

REMARKS

Federal Report SRS-NCSS-120 report format is specified on National Center for Social Statistics form OMB No. 83R-0295.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS SRS-NCSS-120, Part III	MR-O-29

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED / MINIMAL
		The report format and report items for this output are specified by the National Center for Social Statistics on Form OMB No. 83R-0295. All report items can be supported by the Model System design.	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Operational Performance Summary	MR-O-Ø8
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Operations Module Process Step M3.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1. Operations (Level II)
2. Administration (Level II)
3. Recipient Relations (Level II)
4. Provider Relations (Level II)
5.

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

The Operational Performance Summary presents key information reflecting the receipt, processing, and payment of provider claims. This report is intended for higher levels of management in order that they may review the progress of claims processing operations and develop plans accordingly. Information is presented by various time periods in order to establish a basis of reference for evaluation of progress.

REMARKS

RUN DATE 6/30/72
MONTH OF JUNE

OPERATIONAL PERFORMANCE SUMMARY

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG THIS YEAR	:::: FISCAL YEAR-TO-DATE :::: THIS YEAR	LAST YEAR
PHYSICIAN SERVICES						
TOTAL CLAIMS PROCESSED	(8.01)	54,736	52,810	53,650	651,832	596,840
PERCENT APPROVED	(8.02)	92.2 %	90.3 %	92.4 %	91.4 %	88.3 %
PERCENT APPROVED WITHOUT SUSPENSION	(8.03)	80.2 %	79.7 %	80.1 %	79.9 %	76.5 %
PERCENT REJECTED	(8.04)	3.6 %	7.2 %	5.4 %	5.8 %	8.1 %
AVERAGE ERRORS PER CLAIM	(8.05)	.15	.23	.19	.20	.24
PERCENT CHANGE IN SUSPENSE FILE	(8.06)	27.1 %-	4.1 %	N/A	N/A	N/A
AVERAGE DAYS FROM SERVICE DATE TO ENTRY	(8.07)	10.5	15.3	9.2	10.3	17.7
AVERAGE DAYS FROM ENTRY DATE TO APPROVAL	(8.08)	22.2	21.4	22.8	21.1	21.3
AVERAGE DAYS FROM APPROVAL TO PAYMENT	(8.09)	1.3	1.5	1.4	1.1	1.3
AVERAGE DAYS FROM ENTRY DATE TO PAYMENT	(8.10)	23.5	22.9	24.2	22.2	22.6
CLAIMS IN PROCESS AT MONTH END	(8.11)	17,501	17,288	17,366	N/A	N/A
TOTAL CHARGE AMOUNT OF CLAIMS IN PROCESS AT MONTH END	(8.12)	205,812	236,829	206,950	N/A	N/A
NUMBER OF CLAIMS IN PROCESS AT MONTH END AS A PERCENT OF TOTAL CLAIMS RECEIVED THIS MONTH	(8.13)	38.5 %	46.9 %	40.3 %	N/A	N/A

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø8

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Operational Performance Summary	MR-O-Ø8

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
8.01	Total Claims Processed	The number of claims processed by the claims processing system. This count includes new claims received during the month plus claims released from the suspense file.	X	
8.02	Percent Approved	The percent of the total claims processed that were approved for payment.	X	
8.03	Percent Approved Without Suspension	The percent of the total claims processed that were approved for payment without being placed on the suspense file pending error correction.	X	
8.04	Percent Rejected	The percent of the total claims processed that were denied or returned to the provider for error correction.	X	
8.05	Average Errors Per Claim	The total number of claim errors detected divided by the total number of claims processed.		
8.06	Percent Change in Suspense File	The change in the size of the suspense file from the beginning of the month to the ending of the month expressed as a percent of the beginning month claim count.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS Operational Performance Summary MR-O-Ø8

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
8.07	Average Days From Service Date To Entry	The average number of elapsed days from the last date of service on the claim to the date the claim is received by the claims processing agency.	X	
8.08	Average Days From Entry Date To Approval	The average number of elapsed days from the date the claim is received by the claims processing agency to the date the claim is approved for payment by the claims processing system.	X	
8.09	Average Days From Approval To Payment	The average number of days from the date the claim is approved for payment to the date the check to the provider is written.	X	
8.10	Average Days From Entry Date To Payment	The average number of days from the date the claim is received by the claims processing agency to the date the check to the provider is written.	X	
8.11	Claims In Process At Month End	The number of claims in the suspense file at the end of the month.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM	MARS Operational Performance Summary		MR-0-Ø8
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
8.12	Total Charge Amount of Claims In Process at Month End	The total of all charges shown on claims in the suspense file at month end.	X
8.13	Number of Claims In Process at Month End as a Percent of Total Claims Received This Month	The number of claims in the suspense file at month end divided by the number of new claims received during the month.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Claims Processing Performance Analysis	MR-O-Ø9
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Operations Module Process Step M3.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1. Operation (Level III)
2.
3.
4.
5.

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide an overview of the entire claims processing operation. The report provides information for each Category of Service as to claims receipt, claim error correction activity, and final claim disposition statistics. The report is intended to be a measure of performance for scheduling and planning.

REMARKS

RUN DATE 6/30/72

MONTH OF JUNE

CLAIMS PROCESSING PERFORMANCE ANALYSIS

		CATEGORY OF SERVICE							TOTAL ALL CAT.
		INPATIENT	OUT-PATIENT	NURSING HOMES	PHYSICIAN SERVICES	PRESC DRUGS	PERIODIC SCREEN	OTHER	
NEW CLAIMS	9.01	4,712	5,167	2,951	46,646	152,251	1,278	2,285	215,290
NUMBER NEW CLAIMS APPROVED	9.02	4,612	5,063	2,910	44,314	144,662	1,257	2,103	204,921
PERCENT APPROVED	9.03	97.5 %	97.8 %	98.5 %	94.6 %	95.3 %	98.8 %	92.1 %	94.8 %
NUMBER NEW CLAIMS REJECTED	9.04	49	40	12	1,399	6,090	6	137	7,733
PERCENT REJECTED	9.05	1.3 %	1.4 %	0.1 %	3.3 %	4.2 %	0.4 %	6.1 %	4.3 %
NUMBER NEW CLAIMS SUSPENDED	9.06	51	64	29	933	1,499	15	45	2,636
PERCENT SUSPENDED	9.07	1.2 %	1.1 %	1.2 %	2.1 %	1.3 %	1.4 %	2.3 %	1.1 %
PERCENT SUSPENDED THEN RELEASED	9.08	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
PERCENT SUSPENDED MORE THAN ONCE	9.09	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
BEGINNING MONTH SUSPENDED BALANCE	9.10	1,245	1,987	212	24,038	190,692	2,392	3,057	233,623
CLAIMS RELEASED	9.11	198	65	65	8,090	116,968	1,270	1,890	128,650
NUMBER SUSPENDED CLAIMS APPROVED	9.12	124	136	43	6,422	96,940	982	1,690	106,337
PERCENT APPROVED	9.13	9.7 %	7.0 %	20.1 %	27.3 %	51.0 %	41.3 %	54.8 %	47.6 %
NUMBER SUSPENDED CLAIMS REJECTED	9.14	14	20	8	1,048	8,609	216	96	10,011
PERCENT REJECTED	9.15	1.2 %	1.4 %	4.3 %	4.4 %	4.8 %	9.3 %	3.3 %	4.2 %
NUMBER SUSPENDED AGAIN	9.16	30	42	14	620	11,420	72	104	12,302
PERCENT SUSPENDED AGAIN	9.17	2.1 %	1.7 %	7.3 %	3.2 %	5.8 %	3.4 %	3.2 %	6.1 %
PERCENT SUSPENDED MORE THAN TWICE	9.18	0.0 %	0.0 %	3.3 %	1.1 %	1.9 %	0.0 %	0.0 %	1.2 %
CLAIMS NOT RELEASED	9.19	1,077	1,789	147	15,948	73,723	1,122	1,167	94,973
PERCENT NOT RELEASED	9.20	87.0 %	90.2 %	69.0 %	66.0 %	66.5 %	38.9 %	37.7 %	41.9 %
TOTAL CLAIMS PROCESSED	9.21	4,880	5,365	3,016	54,736	269,220	2,548	4,151	343,940
TOTAL CLAIMS APPROVED	9.22	4,736	5,199	2,953	50,736	241,602	2,239	3,793	311,258
PERCENT APPROVED	9.23	97.2 %	97.6 %	98.3 %	92.2 %	90.4 %	88.1 %	90.6 %	90.4 %
TOTAL CLAIMS REJECTED	9.24	63	60	20	2,447	14,699	222	233	17,744
PERCENT REJECTED	9.25	1.2 %	1.3 %	0.4 %	3.6 %	5.5 %	9.3 %	6.4 %	5.4 %
TOTAL CLAIMS SUSPENDED	9.26	81	106	43	1,553	12,919	87	149	14,938
PERCENT SUSPENDED	9.27	1.6 %	1.1 %	0.3 %	4.2 %	4.1 %	2.6 %	3.0 %	4.2 %
PERCENT SUSPENDED MORE THAN ONCE	9.28	1.1 %	1.2 %	0.4 %	0.6 %	4.1 %	3.0 %	2.2 %	4.1 %
SUSPENDED CLAIM BALANCE MONTH END	9.29	1,158	1,895	190	17,501	86,642	1,209	1,316	109,911
NET SUSPENSE FILE CHANGE	9.30	87-	92-	22-	6,537-	104,050-	1,183-	1,741-	113,712-
PERCENT CHANGE IN SUSPENSE FILE	9.31	7.2 %-	5.3 %-	10.1 %-	27.1 %-	55.1 %-	49.4 %-	57.1 %-	51.3 %
NO. CLAIMS IN SUSPENSE AS A % OF NEW CLAIMS	9.32	25.3%	37.1 %	6.0 %	37.8 %	56.3 %	95.5 %	58.0 %	51.0 %

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø9

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS Claims Processing Performance Analysis — MR-O-Ø9

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
9.01	New Claims	The number of claims entering the computer system for the first time this month.	X
9.02	Number New Claims Approved	The number of claims approved for payment.	
9.03	Percent Approved	The percentage of new claims entering the system that were approved for payment without being suspended (9.02 ÷ 9.01 x 100).	X
9.04	Number New Claims Rejected	The number of new claims returned to providers.	X
9.05	Percent Rejected	The percentage of new claims entering the system that were returned to providers (9.04 ÷ 9.01 x 100).	X
9.06	Number New Claims Suspended	The number of new claims suspended. Claims suspended more than once are counted only once.	
9.07	Percent Suspended Again	The percentage of new claims that were suspended (9.06 ÷ 9.01 x 100).	X
9.08	Percent Suspended Then Released	The percentage of new claims that were suspended and subsequently released for approval, rejection or resuspension.	

SUBSYSTEM MARS Claims Processing Performance Analysis MR-O-Ø9

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
9.09	Percent Suspended More Than Once	The percentage of new claims that were suspended, subsequently released for approval, and then resuspended again during the first month the claim was in the system.	X
9.10	Beginning Month Suspended Balance	The number of claims that were in a suspended status at the start of this month.	X
9.11	Claims Released	The number of claims that were in a suspended status at the start of this month but were subsequently released for processing.	X
9.12	Number Suspended Claims Approved	The number of claims that were in a suspended status at the start of this month and subsequently released and approved for payment.	X
9.13	Percent Approved	The percentage of claims that were in a suspended status at the start of this month and then subsequently released and approved for payment (9.12 ÷ 9.10 x 100).	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM	MARS Claims Processing Performance Analysis		MR-0-Ø9
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED / MINIMAL
9.14	Number Suspended Claims Rejected	The number of claims in a suspended status at the start of the month that were released for processing and subsequently rejected.	X
9.15	Percent Rejected	The percentage of claims in a suspended status at the start of the month that were released for processing and subsequently rejected (9.14 ÷ 9.10 x 100).	X
9.16	Number Suspended Again	The number of claims in a suspended status at the start of the month that were released for processing and subsequently resuspended.	X
9.17	Percent Suspended	The percentage of claims in a suspended status at the start of this month that were released for processing and subsequently resuspended (9.16 ÷ 9.10 x 100).	X
9.18	Percent Suspended More Than Twice	The percentage of claims in a suspended status at the start of the month that were subsequently released and resuspended two or more times this month.	X
9.19	Claims Not Released	The number of claims in a suspended status at the start of the month that had no change in status during the month.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Claims Processing Performance Analysis	MR-O-Ø9

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
9.20	Percentage Not Released	The percentage of claims in a suspended status at the start of the month that had no status change during the month (9.19 ÷ 9.10 x 100).	X	
9.21	Total Claims Processed	The number of claims that were processed by the claims processing system. This count includes new claims received during the month plus claims released from the suspense file.	X	
9.22	Total Claims Approved	The number of claims that were approved for payment this month.	X	
9.23	Percent Approved	The percentage of claims that were approved for payment this month (9.22 ÷ 9.21 x 100).	X	
9.24	Total Claims Rejected	The number of claims that were denied or returned to the provider for error correction (9.04 ÷ 9.14).	X	
9.25	Percent Rejected	The percentage of claims that were denied or returned to the provider for error correction (9.24 ÷ 9.21 x 100).	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION		
SUBSYSTEM	MARS Claims Processing Performance Analysis		MR-0-Ø9	
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
9.26	Total Claims Suspended	The number of claims that were suspended during this month's processing (9.06 + 9.16).	X	
9.27	Percent Suspended	The percentage of claims that were suspended during this month's processing (9.26 ÷ 9.21).	X	
9.28	Percent Suspended More Than Once	The percentage of claims that were suspended more than once during this month's processing.	X	
9.29	Suspended Claim Balance Month End	The number of claims in a suspended status at the end of the month's processing.	X	
9.30	Net Suspense File Change	The increase or decrease in the number of claims in the suspense file (9.10 - 9.29). A negative value indicates a decrease in the suspense file.	X	
9.31	Percent Change in Suspense File	The net change in the suspense file expressed as a percentage (9.30 ÷ 9.29 x 100). A negative value indicates a decrease in the suspense file.	X	
9.32	Number of Claims in Suspense as a Percent of New Claims	The number of claims in the suspense file at month's end expressed as a percentage of all new claims processed this month (9.29 ÷ 9.01 x 100).	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Claims Processing Thruput Analysis	MR-0-1Ø
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsytem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Operations Module Process Step M3.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Operations (Level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

Analyze the effectiveness of the Claims Processing Subsystem in terms of capability to process and adjudicate provider claims in an acceptable time frame. The calculation of the time required for payment will be based on the entry date of the claim into the system and the actual date of claim approval.

REMARKS

RUN DATE 6/30/72
MONTH OF JUNE

CLAIMS PROCESSING THRUPUT ANALYSIS

CATEGORY OF SERVICE	PERCENT OF CLAIMS APPROVED THIS MONTH WITHIN 10 DAYS	20 DAYS	30 DAYS	45 DAYS	60 DAYS	90 DAYS	AVG. DAYS REQUIRED FOR APPROVAL
INPATIENT SERVICES	80.2	94.3	98.1	98.1	99.2	100.0	11.1
OUTPATIENT SERVICES	81.2	89.4	98.3	98.3	99.2	100.0	11.4
NURSING HOMES	93.4	96.3	99.1	99.2	99.2	99.2	8.7
PHYSICIAN SERVICES	91.2	93.4	96.2	96.2	97.3	98.1	9.6
DENTAL SERVICES	80.4	92.4	94.5	97.3	98.2	99.3	11.3
LAB AND X-RAY	83.1	93.5	96.4	98.3	98.3	99.4	10.6
PRESCRIPTION DRUGS	95.2	96.4	99.3	99.1	99.1	100.0	9.3
HOME HEALTH	93.3	98.5	99.2	99.2	100.0	100.0	9.3
PERIODIC SCREENING	93.4	96.2	98.3	99.4	100.0	100.0	9.3
OTHER	81.2	93.4	97.3	97.3	99.3	99.3	10.6
ALL CLAIMS	90.5	94.4	98.0	98.4	98.8	99.7	9.2

(10.01) (10.02)

VII-100

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-1Ø

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS Claims Processing Thruput Analysis MR-O-1Ø

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
10.01	Percent of Claims Approved This Month Within 10 Days, 20 Days, 30 Days, 45 Days, 60 Days, 90 Days	Percentages of claims approved for payment by elapsed days measured from the date the claim is received by the claims processing agency to the date the claim is approved for payment by the computer system.	X	
10.02	Average Days Required for Approval	The average number of elapsed days from the date the claim is received by the claims processing agency to the date the claim is approved for payment by the computer system.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Error Distribution Analysis	MR-0-11
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Operations Module Process Step M3.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations (Level III)
2.	Operations (Level III)
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide a summary report on the error and rejection rates being experienced in claims processing activities. The report will indicate in which Category of Service errors are increasing and what errors are occuring most frequently. It is intended to assist in provider education and forms design as well as training of claims processing personnel.

REMARKS

RUN DATE 6/30/72

PAGE NO 01

MONTH OF JUNE

ERROR DISTRIBUTION ANALYSIS

		CATEGORY OF SERVICE											
		INPATIENT		OUTPATIENT		NURSING HOMES		PHYSICIAN SERVICES		PRESCRIP. DRUGS		OTHER	
		THIS MO.	PREV 3 MO.	THIS MO.	PREV 3 MO.	THIS MO.	PREV 3 MO.	THIS MO.	PREV 3 MO.	THIS MO.	PREV 3 MO.	THIS MO.	PREV 3 MO.
NUMBER CLAIMS PROCESSED	(11.01)	4,880	4,622	5,365	5,622	3,016	2,860	54,736	53.620	269,220	270,819	6,723	7,741
CLAIMS APPROVED	(11.02)	4,736	4,438	5,199	5,453	2,953	2,745	50,736	49,330	241,602	249,153	6,032	7,121
PERCENT APPROVED	(11.03)	97.3 %	96.2 %	97.2 %	97.3 %	97.9 %	95.8 %	93.2 %	92.1 %	90.4 %	91.9 %	90.3 %	92.3 %
PERCENT APPROVED WITHOUT ERROR	(11.04)	92.2 %	92.9 %	94.8 %	94.1 %	96.5 %	95.7 %	92.2 %	92.3 %	95.3 %	95.8 %	94.3 %	95.1 %
PERCENT APPROVED WITH 1 ERROR CORRECTED	(11.05)	7.1 %	7.3 %	4.4 %	5.3 %	3.4 %	3.5 %	6.8 %	6.7 %	4.8 %	4.7 %	5.8 %	3.9 %
PERCENT APPROVED WITH MORE THAN 1 CORRECTED ERROR	(11.06)	1.2 %	0.0 %	1.1 %	1.3 %	0.0 %	1.2 %	1.1 %	1.4 %	0.0 %	1.0 %	0.0 %	1.1 %
TOTAL NUMBER OF APPROVED CLAIM ERRORS	(11.07)	1,170	969	804	810	121	96	9,622	9,899	22,623	19,818	962	873
ERRORS THIS SERVICE AS A PERCENT OF ALL ERRORS	(11.08)	3.4 %	3.2 %	2.3 %	2.1 %	1.3 %	1.4 %	27.3 %	30.4 %	64.2 %	60.8 %	3.2 %	3.2 %
PERCENT OF CLAIMS REQUIRING OVERRIDE	(11.09)	1.4 %	0.0 %	0.1 %	0.1 %	0.2 %	0.2 %	1.3 %	1.1 %	0.2 %	0.9 %	0.3 %	0.8 %
NUMBER CLAIMS REJECTED	(11.10)	63	60	60	62	20	19	2,447	2,286	14,699	15,033	455	622
PERCENT CLAIMS REJECTED	(11.11)	1.1 %	1.1 %	0.9 %	0.7 %	1.0 %	1.1 %	3.8 %	4.2 %	5.1 %	5.9 %	6.8 %	8.3 %
AVG. ERRORS PER CLAIM	(11.12)	.25	.22	.15	.15	.04	.04	.19	.19	.09	.08	.16	.11

TEN MOST PREVALENT ERROR CONDITIONS: (11.13)

ERROR CODE	NUMBER OF ERRORS	PERCENT OF ALL ERRORS
118	968	5.9 %
125	872	5.4 %
112	860	5.2 %
152	750	4.3 %
116	540	3.4 %

REPORT FORMAT SAMPLE
OUTPUT NO. MR-O-11

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Error Distribution Analysis	MR-O-11

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
11.01	Number Claims Processed	The total number of claims adjudicated by the claims processing system. The columns headed "Prev 3 Mo" contain a monthly average for the three month period ending with the current month.	X	
11.02	Claims Approved	The number of claims processed that were approved for payment.	X	
11.03	Percent Approved	The percent of the Claims processed that were approved for payment	X	
11.04	Percent Approved without Error	The percent of claims approved that did not require correction of any errors.	X	
11.05	Percent Approved with One Error Corrected	The percent of claims approved that required correction of only one error.	X	
11.06	Percent Approved with More Than One Corrected Error	The percent of claims approved that required correction of more than one error.	X	
11.07	Total Number of Approved Claim Errors	The total number of corrected errors on claims approved for payment.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM	MARS Error Distribution Analysis		MR-O-11
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED / MINIMAL
11.08	Errors This Service as a Percent of All Errors	The errors on claims in each category of service as a percent of all Medicaid claim errors encountered.	X
11.09	Percent of Claims Requiring Override	The percentage of approved claims initially detected as having an error but subsequently determined not to be in error and consequently requiring application of an error override.	X
11.10	Number Claims Rejected	The number of claims that were denied or required return to the provider for error correction.	X
11.11	Percent Claims Rejected	The percent of total claims processed that were rejected.	X
11.12	Average Errors Per Claim	The total number of claim errors detected divided by the total number of claims processed.	X
11.13	Ten Most Prevalent Error Conditions	The ten most frequent errors showing the identifying error codes, the number of occurrences, and the percentage each error represents of all claim errors encountered in the total claims processed.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Participation Summary	MR-O-Ø6
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Administrative Module Process Step M2.2	Monthly
	MEDIA
	Stock paper

DISTRIBUTION

1.	Administration (Level II)
2.	Provider Relations (Level II)
3.	Operations (Level II)
4.	Recipient Relations (Level II)
5.	

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide program management with pertinent information relative to provider activity within the various types of services rendered. Key provider statistical data is presented with respect to periods of time to enable management to interpret the general tendency of provider activity.

REMARKS

RUN DATE 5/3/72
MONTH OF APRIL

PROVIDER PARTICIPATION SUMMARY

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	::::FISCAL YEAR-TO-DATE:::: THIS YEAR	LAST YEAR
PHYSICIAN SERVICES						
NUMBER OF PROVIDERS ENROLLED	(6.01)	8,802	7,840	8,846	8,911	8,103
NUMBER OF PROVIDERS PARTICIPATING	(6.02)	5,721	5,149	5,556	6,700	5,933
PERCENT OF PROVIDERS PARTICIPATING	(6.03)	65.9%	65.7%	62.8%	75.2%	73.2%
CLAIMS PAID PER PARTICIPATING PROVIDER	(6.04)	16.3	17.6	16.8	16.1	17.1
ELIGIBLE RECIPIENTS PER PARTICIPATING PROVIDER	(6.05)	21.3	22.3	21.6	21.7	23.0

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-Ø6

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Provider Participation Summary	MR-O-Ø6

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
6.01	Number of Providers Enrolled	The number of providers that have agreed to participate in the Medicaid Program or, if provider agreements are not required, the number that have participated in the past.	X	
6.02	Number of Providers Participating	An unduplicated count of the number of providers that rendered services to Medicaid recipients in the time period shown.	X	
6.03	Percent of Providers Participating	The number of providers participating as a percent of the providers enrolled.	X	
6.04	Claims Paid Per Participating Provider	The total number of claims paid for the category of service divided by the number of participating providers.	X	
6.05	Eligible Recipients Per Participating Provider	The number of recipients eligible for benefits from Medicaid divided by the number of participating providers.	X	

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Participation Analysis	MR-0-12
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Operations Module Process Step M4.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Administration (Level III)
2.	Provider Relations (Level III)
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

The report provides an in-depth analysis of provider participation by an examination of payments, services rendered, and recipients served by Category of Service. Computations relating these factors of provider participation are presented by time periods in order to establish service and participation trends for planning and control.

REMARKS

RUN DATE 02/29/72

PAGE NO 01

MONTH OF FEBRUARY

PROVIDER PARTICIPATION ANALSIS

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	TREND	FISCAL YEAR-TO-DATE THIS YEAR	FISCAL YEAR-TO-DATE LAST YEAR
PHYSICIAN SERVICES							
NUMBER OF PROVIDERS PARTICIPATING	(12.01)	5,589	4,973	5,487	.002	6,212	5,711
TOTAL RECIPIENTS SERVED	(12.02)	56,857	50,324	56,933	.998	66,468	58,252
AVG. RECIPIENTS PER PROVIDER	(12.03)	10.1	10.1	10.3	.009	10.7	10.2
TOTAL XIX PAYMENTS	(12.04)	$845,623	$776,000	$874,187	.003	$7,387,160	$7,100,812
AVG. PAYMENT PER PROVIDER	(12.05)	$151.30	$154.04	$159.31	.002	$1,189.17	$1,243.45
AVG. PAYMENT PER RECIPIENT	(12.06)	$14.87	$15.42	$15.35	.011	$14.81	$15.15
TOTAL THIRD PARTY PAYMENT	(12.07)	$46,832	$58,652	$56,333	.002	$321,911	$319,678
PERCENT CLAIMS WITH THIRD PARTY PAYMENT	(12.08)	13.0 %	14.0 %	13.5 %	.001	13.9 %	13.7 %
TOTAL UNITS OF SERVICE RENDERED	(12.09)	106,969	95,705	106,486	.015	881,186	879,325
AVG. SERVICE UNITS PER PROVIDER	(12.10)	19.1	19.2	19.4	.006	141.85	153.97
AVG. SERVICE UNITS PER RECIPIENT	(12.11)	1.8	1.9	1.8	.079	13.2	15.1
AVG. PAYMENT PER SERVICE UNIT	(12.12)	$7.93	$8.10	$8.20	.017	$8.38	$8.07

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-12

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Provider Participation Analysis	MR-O-12

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
12.01	Number of Providers Participating	An unduplicated count of the number of providers that rendered services to Medicaid recipients in the time period shown.	X	
12.02	Total Recipients Served	An unduplicated count of the number of recipients receiving Medicaid benefits during the time period shown.	X	
12.03	Average Recipients Per Provider	The number of recipients receiving benefits from Medicaid divided by the number of participating providers (12.02 ÷ 12.01).	X	
12.04	Total XIX Payments	The Medicaid expenditure for medical services to Medicaid recipients.	X	
12.05	Average Payment Per Provider	The average amount paid to participating providers for services rendered.	X	
12.06	Average Payment Per Recipient	The average Medicaid expenditure for recipients receiving Medicaid benefits.	X	
12.07	Total Third Party Payment	The total amount of third party payments reported by providers on submitted Medicaid claims.	X	

SUBSYSTEM MARS Provider Participation Analysis MR-O-12

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
12.08	Percent Claims with Third Party Payment	The number of claims containing payment from a third party as a percent of the total number of claims filed.	X	
12.09	Total Units of Service Rendered	The total units of service received by Medicaid recipients.	X	
12.10	Average Service Units Per Provider	The average number of service units provided by participating providers.	X	
12.11	Average Service Units Per Recipient	The number of service units rendered divided by the number of recipients receiving service (12.09 ÷ 12.02).	X	
12.12	Average Payment Per Service Unit	The total Medicaid expenditure divided by the total units of service rendered (12.04 ÷ 12.09).	X	

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Cost Settlement Analysis	MR-0-13
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Provider Module Process Step M4.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations (Level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Ratio of Charges to Payments	4.	
2.	Provider Number	5.	
3.	Category of Service	6.	

PURPOSE OF OUTPUT

To present provider relations personnel and financial planners with cost reimbursement data in order that the program will not encounter unexpected liability for provider payments at year-end. The report analyzes each provider in terms of his charge versus payment pattern this year with respect to last year. For those providers with rapidly increasing or excessive ratios, review and determination of the cause of increase should be in order.

REMARKS

Only those cost settled providers which exceed a selected ratio will be listed.

RUN DATE 6/30/72

MONTH OF JUNE

COST SETTLEMENT ANALYSIS

CATEGORY OF SERVICE: HOSPITAL INPATIENT

PROVIDER NUMBER	LAST YEAR'S NET REIMBURSE.	LAST YEAR'S CHARGES	LAST YEAR'S REIMB. AS A % OF CHARGES	THIS YEAR'S PAYMENTS	THIS YEAR'S CHARGES	THIS YEAR'S PAYMENT AS A % OF CHARGES	OVER OR (UNDER) PAYMENT BASED ON DIFFERENCE IN LAST YEAR'S REIMB. % AND THIS YEAR'S PAYMENT %
1234567	48,018	52,628	91.2 %	48,596	52,790	92.1 %	475
1345678	95,869	106,411	90.1 %	110,073	120,321	91.5 %	1,684
1543678	67,481	75,742	89.1 %	77,968	85,123	91.6 %	2,128
1553521	463,521	511,321	90.7 %	493,622	554,169	89.1 %	(8,866)
1564523	225,386	263,646	85.5 %	241,298	287,003	84.1 %	(4,018)
(13.01)	(13.12)	(13.03)	(13.04)	(13.05)	(13.06)	(13.07)	(13.08)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-13

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Cost Settlement Analysis	MR-O-13

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
13.01	Provider Number		
13.02	Last Year's Net Reimbursement	The total amount paid to the provider for Medicaid services plus (or minus) the cost settlement adjustment determined at the end of the fiscal year. This, or any other figures on this report, does not include any payments made for Medicare deductibles or co-insurance.	X
13.03	Last Year's Charges	The total amount of claim charges filed by the provider for Medicaid services rendered.	X
13.04	Last Year's Reimbursement as a Percent of Charges	Item 13.02 divided by item 13.03 multiplied by 100.	X
13.05	This Year's Payments	The total amount of interim payments made in the current fiscal year-to-date period.	X
13.06	This Year's Charges	The total amount of claim charges filed by the provider for Medicaid services on claims paid in the current fiscal year-to-date period.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM	MARS Cost Settlement Analysis	MR-O-13	
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED / MINIMAL
13.07	This Year's Payment as a Percent of Charges	Item 13.05 divided by item 13.06 multiplied by 100.	X
13.08	Over (or Under) Payment Based on Difference in Last Year's Reimbursement Percent and This Year's Payment Percent	The estimated fiscal year-to-date cost settlement adjustment amount [(13.07 - 13.04) x 13.06].	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Cost Settlement Details	MR-0-14
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Provider Module Process Step M4.2	As requested
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations (level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.	Category of Service	5.	
3.	Charge Code	6.	

PURPOSE OF OUTPUT

Provide fiscal year charges and statistics which will assist in the verification of provider cost settlement.

REMARKS

Report should be requested the month after the provider's fiscal year end.

COST SETTLEMENT DETAILS

INPATIENT HOSPITAL SUMMARY

1234567 (14.01)
GENERAL HOSPITAL
MAINSTREET (14.02)
ANYWHERE, USA

TITLE XVIII CODE: 2345678 (14.03)

REPORT PERIOD START: 8/01/71 (14.04)

REPORT PERIOD END 7/31/72 (14.05)

PAYMENT PERIOD 8/01/71 (14.06)
12/01/72

TOTALS		
TOTAL CHARGES	343,556	(14.07)
AMOUNT PAID BY TITLE XIX	307,850	(14.08)
AMOUNT PAID BY 3RD PARTIES	10,262	(14.09)
AMOUNT PAID FOR TITLE XVIII DEDUCTIBLE & COINSURANCE	23,944	(14.10)

CHARGE CENTER AMOUNTS	
BLOOD	1,500
PRIVATE RM	16,880
SEMIPRIV.	102,340
WARD	96,418
INTEN CARE	30,610
OPER ROOM	15,482

(14.11)

REIMBURSEMENT SCHEDULE		
MODE	FACTOR	EFFECTIVE DATE
2	93.00%	7/01/72
2	89.00%	1/01/73

(14.12)

VII-120

CLAIM DETAIL

RECIPIENT NAME	RECIPIENT IDENTIFICATION	TRANSACTION CONTROL NO.	DATE PAID	SERVICE DATES	DIAG CODES	DAYS REG	DAYS NURS	CHARGES		PAYMENTS		
JONES H A	123-456-789	72103-1234	5/30/72	2/12/72 2/15/72	7523	3	0	BLOOD 2-4 BED RM OP. ROOM RADIOLOGY	22.00 200.00 175.00 37.00	MEDICAID 3RD PARTY	340.00 50.00	(14.21) (14.22)
								TOTAL	434.00			
BROWN B B	125-615-384	72099-0055	5/30/72	3/01/72 3/15/72	5185	9	0	WARD RADIOLOGY LABORATORY	450.00 75.00 125.00	MEDICAID	500.00	
								TOTAL	650.00			

(14.13) (14.14) (14.15) (14.16) (14.17) (14.18) (14.19) (14.20)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-14

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS Cost Settlement Details MR-O-14

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
14.01	Provider Number		X
14.02	Provider Name and Address		X
14.03	Title XVIII Provider Code	The provider number assigned to the provider by the Medicare intermediary.	X
14.04	Report Period Start	Beginning date of period covered by this report.	X
14.05	Report Period End	Ending date of period covered by this report.	X
14.06	Payment Period	Provider cost data reflects only claims for service that were both rendered in the period shown and paid by Medicaid within the payment period shown.	X
14.07	Total Charges	Total amount of all Title XIX claim charges filed by the provider during the period shown.	X
14.08	Amount Paid by Title XIX	The total amount paid by Medicaid to the provider during the period.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Cost Settlement Details	MR-O-14

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
14.09	Amount Paid By Third Parties	The total amount paid by third party sources to the provider for claims on Medicaid recipients and thus reducing Title XIX liability. Medicare payments are not considered to be third party payments.	X	
14.10	Amount Paid For Title XVIII Deductible And Coinsurance	The amount paid by Medicaid to the provider for deductible and coinsurance amounts not paid by Medicare. This amount is included in item 14.08.	X	
14.11	Charge Center Amounts	The total amount of claims charges (item 14.07) broken out by the individual charge centers used by providers in accounting for patient costs.	X	
14.12	Reimbursement Schedule	Mode: Code reflecting the method by which the provider is reimbursed. The number 1 indicates payment on the basis of a per diem rate; 2 indicates payment on the basis of percent of billed charges. Factor: The per diem rate if the mode code is 1; the percentage factor if mode code is 2. Effective Date: The date on which the reimbursement factor shown became effective.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Cost Settlement Details -	MR-O-14

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
14.13	Recipient Name	Name of recipient whose individual claim detail is shown (D.E. 103).	X	
14.14	Recipient Identification	Medicaid identification number of recipient whose claim is shown (D.E. 101).	X	
14.15	Transaction Control Number	Number assigned by claims processing agency to provide a unique identification for recipient claim shown (D.E. 300).	X	
14.16	Date Paid	Date check was issued to provider covering payment of claim shown (D.E. 376).	X	
14.17	Service Dates	Inclusive dates on which services were rendered for claim shown (D.E. 312 and 313).	X	
14.18	Diagnosis Codes	ICDA codes relating to the services indicated on the claim shown (D.E. 306 and 307).	X	
14.19	Days Regular/Nursery	The number of patient days and infant days (where applicable) covered by the claim shown.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS Cost Settlement Details MR-O-14

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
14.20	Charges	The individual charges incurred in the provider charge centers for the claim shown.	X
14.21	Medicaid Payment	Total amount of Title XIX payment for claim shown.	X
14.22	Third Party Payment	Total amount of third party payment that was applied against the charges for the claim shown.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Claim Filing Analysis	MR-0-15
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/03/73

SOURCE OF OUTPUT DATA	FREQUENCY
Provider Module Process Step M4.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Administration (Level III)
2.	Provider Relations (Level III)
3.	
4.	
5.	

SEQUENCE

1.	Category of Services	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

The Provider Claim Filing Analysis is designed to assist financial management and provider relations personnel in determining which areas of provider services have the greatest delay between the dates of service and the date the claim is received by the Medicaid claims processing agency. Excessive delays in claim filing distort statistical data and can cause financial problems in budgeting.

REMARKS

RUN DATE 06/30/72

PAGE NO 01

MONTH OF JUNE

PROVIDER CLAIM FILING ANALYSIS

		INPATIENT	OUTPATIENT	NURSING HOMES	PHYSICIAN SERVICES	DENTAL SERVICES	LAB AND X-RAY	PRESCRIP. DRUGS	OTHER SERVICES	TOTAL ALL CATEGORIES
TOTAL CLAIMS APPROVED	(15.01)	4,736	5,199	2,953	50,736	3,006	356	241,602	2,670	311,258
TOTAL AMOUNT PAID	(15.02)	731,409	58,983	945,276	596,672	60,765	3,306	929,736	25,915	3,352,062
AVERAGE DAYS TO FILING	(15.03)	35	28	10	12	17	25	14	18	20
CLAIMS RECEIVED IN 1-30 DAYS FROM LAST DATE OF SERVICE:	(15.04)	2,936	3,795	2,775	47,691	2,404	242	236,769	2,189	298,801
PERCENT OF TOTAL CLAIMS APPROVED	(15.05)	62%	73%	94%	94%	80%	68%	98%	82%	87%
AMOUNT OF PAYMENT	(15.06)	453,473	43,057	888,559	560,871	48,612	2,248	911,141	21,250	2,929,211
CLAIMS RECEIVED IN 31-60 DAYS FROM LAST DATE OF SERVICE:		1,420	1,144	89	2,029	511	89	2,416	429	8,125
PERCENT OF TOTAL CLAIMS APPROVED		30%	22%	3%	4%	17%	25%	1%	16%	3%
AMOUNT OF PAYMENT		219,422	12,976	28,358	23,866	10,330	827	9,297	4,146	309,222

(REPEAT FOR -
61-90 DAYS
4-6 MONTHS
MORE THAN 6 MONTHS)

VII-124

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-15

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Provider Claim Filing Analysis	MR-O-15

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
15.01	Total Claims Approved	The number of claims approved for payment in the month covered by the report.	X	
15.02	Total Amount Paid	The amount paid by Medicaid to providers for the claims approved for payment in report item 15.01.	X	
15.03	Average Days to Filing	The average number of days from the last date of service on a claim to the date the claim was received by the claims processing agency for all claims in report item 15.01.	X	
15.04	Claims Received in 1-30 Days, 31-60 Days, 61-90 Days, 4-6 Months, More than 6 Months from Last Date of Service	The number of claims shown in report item 15.01 that were received within the time intervals listed. The time intervals are a measure of the days between the last date of service and the date the claim was received by the claims processing agency.	X	
15.05	Percent of Total Claims Approved	The percent of Total Claims Approved (report item 15.01) represented by the claims shown in each time interval listed in report item 15.04.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Provider Claim Filing Analysis	MR-O-15

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
15.06	Amount of Payment	The amount of payment by Title XIX for claims filed in the time interval listed in report item 15.04.	X	

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Claim Filing Details	MR-0-16
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Provider Module Process Step M4.2	As requested
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations (Level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Average Days Delay	5.	
3.	Provider Number	6.	

PURPOSE OF OUTPUT

To assist provider relations personnel in further analysis of Categories of Service which indicate excessive time delays in the Provider Claim Filing Analysis Report. Providers are ranked by the average number of days delay in filing of their claims.

REMARKS

Days delay will be calculated based on the systems entry date and the last date of service.

RUN DATE 6/30/72

APRIL THRU JUNE

PROVIDER CLAIM FILING DETAILS

CATEGORY OF SERVICE	PROVIDER NUMBER	AVERAGE DAYS TO FILING	CLAIMS RECEIVED IN 1-30 DAYS NUMBER CLAIMS	1-30 DAYS AMOUNT PAID	31-60 DAYS NUMBER CLAIMS	31-60 DAYS AMOUNT PAID	61-90 DAYS NUMBER CLAIMS	61-90 DAYS AMOUNT PAID	4-6 MONTHS NUMBER CLAIMS	4-6 MONTHS AMOUNT PAID	MORE THAN 6 MO NUMBER CLAIMS	MORE THAN 6 MO AMOUNT PAID
PHYSICIAN	1234567	41	48	618	40	480	20	183	1	14	2	32
	2345678	38	24	260	10	99	9	103	2	21		
	3456789	33	92	1,004	70	578	16	208	1	9		
	1063425	26	214	2,322	96	820	13	180			1	64
	5386621	22	165	1,542	38	216	4	39				
			(16.01)	(16.02)	(16.03)		(16.04)					

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-16

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Provider Claim Filing Details	MR-O-16

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
16.01	Provider Number			
16.02	Average Days to Filing	The average number of days from the date of service on a claim to the date the claim was received by the claims processing agency for the claims filed by the provider during the period of time covered by the report.	X	
16.03	Number of Claims Received in 1-30 Days, 31-60 Days, 60-90 Days, 4-6 Months, More than 6 Months	The number of claims received by the claims processing agency in the time intervals listed. The measurement begins with the last date of service on the claim.	X	
16.04	Amount Paid	The amount paid by Title XIX for claims shown in the time intervals listed in report item 16.03.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Third Party Payment Analysis	MR-0-17
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/03/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Provider Module Process Step M4.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1. Provider Relations (Level III)
2.
3.
4.
5.

SEQUENCE

1.	Category of Service	4.	
2.	Provider Specialty Code	5.	
3.	Provider Number	6.	

PURPOSE OF OUTPUT

To assist provider relations personnel in analyzing the response of providers in assisting in the determination of third party liability and payment. The report analyzes each provider in terms of third party data with respect to total claims payment data and individual payment data.

REMARKS

RUN DATE 6/30/72

JANUARY THRU JUNE

THIRD PARTY PAYMENT ANALYSIS

CATEGORY OF SERVICE : PHYSICIAN SERVICES PHYSICIAN SPECIALTY: GENERAL SURGERY

AVG. PERCENT OF CLAIMS WITH THIRD PARTY PAYMENT PER PROVIDER : 17.2 (17.01)

PROVIDER NUMBER	NUMBER OF CLAIMS	NUMBER WITH THIRD PARTY PAYMENT	PERCENT WITH THIRD PARTY PAYMENT	TOTAL CLAIM AMOUNT	THIRD PARTY DOLLARS	THIRD PARTY DOLLARS AS A PERCENT OF TOTAL CLAIM DOLLARS
5234567	603	55	9.1	6,356	597	9.4
5545678	1,182	108	9.1	12,671	1,406	11.1
5456789	528	49	9.2	5,507	677	12.3
5678901	441	41	9.4	4,635	413	8.9
5567890	827	79	9.5	8,973	942	10.5
(17.02)	(17.03)	(17.04)	(17.05)	(17.06)	(17.07)	(17.08)

REPORT FORMAT SAMPLE
OUTPUT NO. MR-O-17

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Third Party Payment Analysis	MR-O-17

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
17.01	Average Percent of Claims with Third Party Payment Per Provider	The percent of claims containing third party payment is computed for each provider. The average of that percent for all providers within the category of service is shown.	X
17.02	Provider Number	Only providers which do not reach a selected percent of third party payment and whose Medicaid payments exceed a minimum level are listed.	X
17.03	Number of Claims	The total number of claims filed in the six month period.	X
17.04	Number with Third Party Payment	The number of claims containing payment from a third party.	X
17.05	Percent with Third Party Payment	The number of claims containing payment from a third party as a percent of the total number of claims filed (17.04 ÷ 17.03 x 100).	X
17.06	Total Claim Amount	The total dollars claimed by the provider as reimbursement for services rendered to recipients for all claims submitted.	X

SUBSYSTEM MARS Third Party Payment Analysis MR-O-17

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
17.07	Third Party Dollars	The total amount of third party payments reported by the provider on all claims submitted.	X	
17.08	Third Party Dollars as a Percent of Total Claim Dollars	Third Party Dollars as a percent of Total Claim Dollars (17.07 ÷ 17.06 x 100).	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Error Frequency Analysis	MR-0-18
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Provider Module Process Step M4.2	Quarterly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations (Level III)
2.	Operations (Level III)
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Errors per 100 claims	5.	
3.	Provider Number	6.	

PURPOSE OF OUTPUT

To determine which providers are experiencing high error rates on their claims and to identify the nature and frequency of these errors. Claim errors can be a result of such factors as poor claim form design, improper completion of claim forms, clerical processing errors, and claim data input errors. The report is intended as a management information tool to assist in training both provider and operations personnel.

REMARKS

RUN DATE 6/30/72

PAGE NO 01

APRIL THRU JUNE

E R R O R F R E Q U E N C Y A N A L Y S I S

CATEGORY OF SERVICE	PROVIDER NUMBER	NUMBER OF CLAIMS PAID	NUMBER OF CLAIMS SUSPENDED	PERCENT PAID FROM SUSPENSE	NUMBER OF REJECTED CLAIMS	NUMBER OF CLAIMS OVERRIDDEN	AVERAGE NUMBER OF ERRORS PER 100 CLAIMS
INPATIENT	6123456	168	13	3.4 %	4	6	7
	6389429	348	19	3.3 %	8	9	6
	6592386	213	15	2.1 %	5	8	6
	(18.01)	(18.02)	(18.03)	(18.04)	(18.05)	(18.06)	(18.07)

ERROR CODE	ERROR DESCRIPTION	PERCENT CLAIMS WITH THIS ERROR	NUMBER OF CLAIMS WITH THIS ERROR
120	PROCEDURE CODE MISSING	3.1 %	21
125	DIAGNOSIS CODE MISSING	2.2 %	17
(18.08)	(18.09)	(18.10)	(18.11)

REJECTION CODE	REJECTION REASON	PERCENT OF REJECTED CLAIMS WITH THIS CODE	NUMBER OF REJECTED CLAIMS WITH THIS CODE
606	RECIPIENT NOT ELIGIBLE	38.3 %	6
600	CASE NUMBER NOT ON FILE	9.2 %	1
(18.12)	(18.13)	(18.14)	(18.15)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-18

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Error Frequency Analysis	MR-O-18

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
18.01	Provider Number		
18.02	Number of Claims Paid	The number of claims paid during the time period covered by the report.	X
18.03	Number of Claims Suspended	The number of claims with one or more correctable errors that were suspended during the time period covered by the report.	X
18.04	Percent Paid From Suspense	The percent of claims in item 18.02 that required correction of one or more errors prior to payment.	X
18.05	Number of Rejected Claims	The number of claims that were denied or required return to the provider for error correction.	X
18.06	Number of Claims Overridden	The number of claims that were paid only after manual intervention to bypass a computer edit.	X
18.07	Number of Errors Per 100 Claims	The average number of errors encountered for each one hundred claims paid.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Error Frequency Analysis	MR-O-18

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
18.08	Error Code	A numeric code assigned to identify each error condition that can be detected by the computer system.	X
18.09	Error Description	A description of the error conditions identified by the error code.	X
18.10	Percent Claims with This Error	The percent of claims in item 18.02 that required correction of this error condition.	X
18.11	Number of Claims with This Error	The number of claims in item 18.02 that required correction of this error condition.	X
18.12	Rejection Code	A numeric code assigned to identify each condition for which a claim may be denied or cause return to the provider for correction.	X
18.13	Rejection Reason	A description of the reason for rejection.	X
18.14	Percent of Rejected Claims with This Code	The percent of rejected claims (item 18.05) that were rejected for this rejection reason.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Error Frequency Analysis	MR-O-18

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
18.15	Number of Rejected Claims with This Code	The number of rejected claims (item 18.05) that were rejected for this rejection reason.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Ranking List	MR-0-19
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Provider Module Process Step M4.2	Annually
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations (Level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Rank by Payment	5.	
3.	Provider Number	6.	

PURPOSE OF OUTPUT

To assist in planning and controlling provider activity by analyzing the extent of participation by individual providers based on the number of claims filed and total payments for the fiscal year. Within each Category of Service providers will be ranked by payment amount from the most total payment to the least.

REMARKS The report will list only those providers whose payments exceed a selected amount. Should this report be desired more frequently than annually, payment totals should be printed to reflect the current reporting period, in addition to showing year-to-date payments.

RUN DATE 6/30/72

JULY THRU JUNE

PROVIDER RANKING LIST

CATEGORY OF SERVICE	PROVIDER NUMBER	PROVIDER NAME	NUMBER CLAIMS	PERCENT OF CATEGORY CLAIMS	PAYMENT	PERCENT OF CATEGORY PAYMENT	AVERAGE PAYMENT	RANK BY PAYMENT
PHYSICIAN	5876302	JONES H C MD	6,785	1.11	115,420	1.61	17.01	1
	5238694	SMITH J P MD	8,570	1.41	109,611	1.53	12.79	2
	5689432	BROWN R C MD	7,608	1.25	90,917	1.27	11.95	3
	5864892	THOMAS H T MD	4,989	.82	80,175	1.12	16.07	4
	(19.01)	(19.02)	(19.03)	(19.04)	(19.05)	(19.06)	(19.07)	(19.08)

VII-140

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-19

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Provider Ranking List	MR-O-19

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
19.01	Provider Number			
19.02	Provider Name			
19.03	Number of Claims	The number of Medicaid claims paid during the year for the provider indicated.	X	
19.04	Percent of Category Claims	Each provider's total number of claims expressed as a percentage of the total number of all claims paid in this category of service.	X	
19.05	Payment	The amount received from Medicaid during the year by the provider indicated.	X	
19.06	Percent of Category Payment	Each provider's total amount paid expressed as a percentage of the total amount paid to all providers in this category of service.	X	
19.07	Average Payment	The average amount paid per claim for the provider indicated.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Provider Ranking List	MR-O-19

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
19.08	Rank By Payment	The provider's ranking within this category of service, based on total Medicaid payments received.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
1099-MED	MR-0-2Ø
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Provider Module Process Step M4.2	Annual
	MEDIA
	Federal Form

DISTRIBUTION

1.	Provider Relations (Level IV)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To comply with Federal Internal Revenue Service requirements that the total payment made to certain providers of medical services be reported. This form will be prepared for all individual providers with Medicaid payments of $600 or more. The exact printed format will be in accordance with Form 1099-MED.

REMARKS

This data may be submitted to the Internal Revenue Service using magnetic tape. For further information regarding submittal by magnetic tape contact the Director of any Internal Revenue Service Center. (See Revenue Procedure 69-16, C.B. 1969-2, 288.)

RUN DATE 1/30/72

PAGE NO. 01

1099 - MED

PROVIDER NUMBER	PROVIDER NAME	SOCIAL SECURITY NUMBER	EMPLOYER IDENTIFICATION NUMBER	TOTAL ANNUAL TITLE XIX PAYMENTS
1234567	DAVIS, JOHN M.D.	309-24-0303		$15,721
(20.01)	(20.02)	(20.03)	(20.04)	(20.05)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-20

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS 1099-MED	MR-O-2Ø

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
20.01	Provider Number		X
20.02	Provider Name		X
20.03	Social Security Number	The account number assigned to individuals by the Social Security Administration.	X
20.04	Employer Identification Number	The number assigned to employers by the Internal Revenue Service for tax reporting purposes. This number is shown in lieu of the Social Security Number if the employer is an institution or business firm.	X
20.05	Total Annual Title XIX Payments	The total reimbursement by Medicaid, for all categories of service, during the calendar year covered by the report.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Drug Usage Frequency Analysis	MR-0-21
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Provider Module Process Step M4.3	Annual
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations (Level III)
2.	Recipient Relations (Level III)
3.	
4.	
5.	

SEQUENCE

1.	Drug Classification Code	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To assist in program planning and control by presenting drug usage information which reflects the most commonly used drugs and drugs having required the greatest expenditure.

REMARKS

RUN DATE 6/30/72

DRUG USAGE FREQUENCY ANALYSIS

DRUG CLASS	DRUG CODE	NUMBER OF PRESCRIPTIONS: TOTAL	PERCENT OF ALL DRUGS	PERCENT OF DRUG CLASS	AVG. QNT. DISPENSED	TOTAL AMOUNT PAID: AMOUNT	PERCENT OF ALL DRUGS	PERCENT OF DRUG CLASS	AVERAGE PAYMENT	USAGE RANK BY TOTAL ALL DRUGS: NUMBER	USAGE RANK BY TOTAL ALL DRUGS: PAYMENT	USAGE RANK BY CLASS: NUMBER	USAGE RANK BY CLASS: PAYMENT
01	1246010	1,232	.2%	52.0%	32	$ 5,231	.2%	42.2%	$ 4.25	46	203	1	2
	1246143	1,142	.6%	49.0%	41	$ 6,831	.1%	55.0%	$ 5.98	81	196	2	1
	2614369	8	1.0%	.3%	16	$ 320	3.0%	3.0%	$40.00	126	223	3	3
CLASS TOTAL		2,382	1.1%			$12,382	.03%		$16.74				
(21.01)	(21.02)	(21.03)	(21.04)	(21.05)	(21.06)	(21.07)	(21.08)	(21.09)	(21.10)	(21.11)	(21.12)	(21.13)	(21.14)
ALL DRUG TOTALS		16,314				$62,321			$26.14				
CLASS SUMMARY													
01		2,382				$12,382			$16.74	1	2		
02		1,163				$14,238			$20.63	2	1		

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-21

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Drug Usage Frequency Analysis	MR-O-21

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
21.01	Drug Class	A code assigned to each drug so that drugs may be grouped by therapeutic qualities (D.E. 5Ø9).	X
21.02	Drug Code	A code assigned to each drug to facilitate identification and manipulation within the computer system (D.E. 5Ø1).	X
21.03	Total Number of Prescriptions		
21.04	Number of Prescriptions as a Percent of All Drugs	The number of prescriptions for each drug divided by the total number of prescriptions for all drugs regardless of their therapeutic classification.	X
21.05	Number of Prescriptions as a Percent of Drug Class	The number of prescriptions for each drug divided by the total number of prescriptions for all drugs in the same therapeutic classification.	X
21.06	Average Quantity Dispensed	The total quantity units dispensed divided by the number of prescriptions for that drug. The definition of a quantity unit varies from drug to drug. Examples of quantity units are pills, ounces, capsules, and tubes.	X

SUBSYSTEM MARS Drug Usage Frequency Analysis MR-O-21

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
21.07	Total Amount Paid	The total expenditure by Medicaid for each drug.	X	
21.08	Total Amount Paid as a Percent of All Drugs	The Medicaid expenditure for each drug divided by the total expenditure for all drugs, regardless of therapeutic classification.	X	
21.09	Total Amount Paid as a Percent of Drug Class	The Medicaid expenditure for each drug divided by the total expenditure for all drugs in the same therapeutic classification.	X	
21.10	Average Payment	The Medicaid expenditure for each drug divided by the number of prescriptions for that drug (21.07 ÷ 21.03).	X	
21.11	Usage Rank By Number of Prescriptions for All Drugs	The relative position of each drug, based on number of prescriptions, to all drugs regardless of therapeutic classification.	X	
21.12	Usage Rank By Payment for All Drugs	The relative position of each drug, based on Medicaid expenditure, to all drugs regardless of therapeutic classification.	X	

SUBSYSTEM MARS Drug Usage Frequency Analysis

MR-O-21

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
21.13	Usage Rank within the Same Therapeutic Classification, Based on Number of Prescriptions	The relative position of each drug, based on number of prescriptions, to all drugs within the same therapeutic classification.	X	
21.14	Usage Rank within the Same Therapeutic Classification, Based on Total Payment	The relative position of each drug, based on Medicaid expenditure, to all drugs within the same therapeutic classification.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report- Physician Summary Class Profiles	SU-O-Ø2
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	
SOURCE OF OUTPUT DATA	**FREQUENCY**
Management Summary Module Process Step U2.1	Monthly
	MEDIA
	Paper

DISTRIBUTION

1. Surveillance and Utilization Review Unit
2. Management and Administrative Reporting Subsystem
3.
4.
5.

SEQUENCE

1.	Category of Service	4.	
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Physician Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of Physician Services.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Recipient Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES			SU-O-Ø2
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
AA	Identification Section		X
Ø1	Category of Service	Category of Service Code (Date Element 3Ø1)	
Ø2	Class Group	Class Group Code (Date Element 7Ø2)	X
BB	Totals Sections Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve month, Current Quarter to Date, and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item.		X
Ø1	Dollars Invoiced-Medicaid	Total dollars invoiced for services rendered by providers in this group under Title XIX	X
Ø2	Dollars Paid-Medicaid	Total dollars paid to providers in this group for services rendered under Title XIX	X
Ø3	Dollars Paid-Medicare	Total dollars paid to providers in this group by Title XIX for Title XVIII Coinsurance and Deductible	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø4	Total Dollars Paid Direct	Grand total dollars paid to providers in this group by Title XIX.	X	
Ø5	Dollars Paid-Svcs. Ordered	Grand dollars paid by Title XIX to other providers for services prescribed or ordered by providers in this group.		X
Ø6	Grand Total Dollars Paid	Grand total dollars paid by Title XIX for all services rendered, prescribed and ordered by providers in this group.		X
Ø7	No. Recipients Served-Medicaid	An unduplicated count of individual recipients served by providers in this group with primary coverage under Title XIX.	X	
Ø8	No. Recipients Served-Medicare	An unduplicated count of individual recipients served by providers in this group with primary coverage under Title XVIII.	X	
Ø9	Total No. Recipients Served	An unduplicated count of all individual recipients served by providers in this group.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
1Ø	No. of Medical Visits-Total	Total number of Medical Visits by providers in this group at all locations	X	
11	No. of Medical Visits-In Hosp.	Total number of Medical Visits by providers in this group at inpatient hospitals		X
12	No. of Medical Visits-Out Hosp.	Total number of Medical Visits by providers in this group at outpatient hospital facilities		X
13	No. of Medical Visits-LTCF	Total number of Medical Visits by providers in this group at long term care facilities		X
14	No. of Medical Visits-Home	Total number of Medical Visits by providers in this group at patients' homes	X	
15	No. of Medical Visits-Office	Total number of Medical Visits by providers in this group at their offices	X	
16	Pmts. for Medical Visits-Total	Total dollars paid to providers in this group for Medical Visits at all locations		X

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
17	Pmts. for Medical Visits-In Hosp.	Total dollars paid to providers in this group for Medical Visits at inpatient hospital facilities		
18	Pmts. for Medical Visits-In Hosp.	Total dollars paid to providers in this group for Medical Visits at outpatient hospital facilities		
19	Pmts. for Medical Visits-LTCF	Total dollars paid to providers in this group for Medical Visits at long term care facilities		
2Ø	Pmts. for Medical Visits-Home	Total dollars paid to providers in this group for Medical Visits at patients' homes		
21	Pmts. for Medical Visits-Office	Total dollars paid to providers in this group for Medical Visits at their offices		
22	No. of Initial Visits-Total	Total Number of Initial Medical Visits by providers in this group at all location		
23	No. of Initial Visits-In Hosp.	Total number of Initial Medical Visits by providers in this group at inpatient hospital facilities		
24	No. of Initial Visits-Out Hosp.	Total number of Initial Medical Visits by providers in this group at outpatient hospital facilities		

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-0-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
25	No. of Initial Visits-LTCF	Total number of Initial Medical Visits by providers in this group at long term care facilities		X
26	No. of Initial Visits-Home	Total number of Initial Medical Visits by providers in this group at patients' homes		X
27	No. of Initial Visits-Office	Total number of Initial Medical Visits by providers in this group at their offices		X
28	No. Recipients Served-In Hosp.	An unduplicated count of individual recipients with Medical Visits by providers in this group at inpatient hospitals		X
29	No. Recipients Served-Out Hosp.	An unduplicated count of individual recipients with Medical Visits by providers in this group at out-patient hospitals		X
3Ø	No. Recipients Served-LTCF	An unduplicated count of individual recipients with Medical Visits by providers in this group at long term care facilities		X
31	No. Recipients Served-Home	An unduplicated count of individual recipients with Medical Visits by providers in this group at their homes		X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
32	No. Recipients Served-Office	An unduplicated count of individual recipients with Medical Visits by providers in this group at their offices		X
33	No. of Injections-Total	Total number of Injections by providers in this group at all locations	X	
34	No. of Injections-Home	Total number of Injections by providers in this group at patients' homes		X
35	No. of Injections-Office	Total number of Injection by providers in this group at their offices		X
36	Pmts. for Injections-Total	Total dollars paid to providers in this group for Injections at all locations	X	
37	Pmts. for Injections-Home	Total dollars paid to providers in this group for Injections at patients' homes		X
38	Pmts. for Injections-Office	Total dollars paid to providers in this group for Injections at their offices		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-0-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
39	No. of Surg. Proc.-Total	Total number of Surgical Procedures by providers in this group at all locations	X	
4Ø	No. of Surg. Proc.-In Hosp.	Total number of Surgical Procedures by providers in this group at inpatient hospitals		X
41	No. of Surg. Proc.-Out Hosp.	Total number of Surgical Procedures by providers in this group at outpatient hospital facilities		X
42	No. of Surg. Proc.-Office	Total number of Surgical Procedures by providers in this group at their offices		X
43	Pmts. for Surgery-Total	Total dollars paid to providers in this group for Surgical Procedures at all locations	X	
44	Pmts. for Surgery-In Hosp.	Total dollars paid to providers in this group for Surgical Procedures at inpatient hospitals		X
45	Pmts. for Surgery-Out Hosp.	Total dollars paid to providers in this group for Surgical Procedures at outpatient hospitals		X

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
46	Pmts. for Surgery-Office	Total dollars paid to providers in this group for Surgical Procedures at their offices.		X
47	No. Surg. Recipients Served-In Hosp.	An unduplicated count of recipients with Surgical Procedures by providers in this group at inpatient hospitals		X
48	No. Surg. Recipients Served-Out Hosp.	An unduplicated count of recipients with Surgical Procedures by providers in this group at outpatient hospital facilities		X
49	No. Surg. Recipients Served-Office	An unduplicated count of recipients with Surgical Procedures by providers in this group at their offices		X
5Ø	No. Diag. Radiology Proc.	Total number of Diagnostic Radiology Procedures by providers in this group	X	
51	Pmts. for Diag. Radiology Proc.	Total dollars paid to providers in this group for Diagnostic Radiology Procedures	X	
52	No. Diag. Lab. Proc.	Total number of Diagnostic Laboratory Procedures by providers in this group	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-0-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
53	Pmts. for Diag. Lab. Proc.	Total dollars paid to providers in this group for Diagnostic Laboratory Procedures	X
54	No. Other Diag. Proc.	Total number of other specific Diagnostic Procedures by providers in this group	X
55	Pmts. for Other Diag. Proc.	Total dollars paid to providers in this group for other specific Diagnostic Procedures	X
56	No. of Consultations	Total number of Consultations by providers in this group	X
57	Pmts. for Consultations	Total dollars paid to providers in this group for Consultations	X
58	No. All Other Services	Total number of all services rendered by providers in this group other than those itemized above	X
59	Pmts. for All Other Services	Total dollars paid for all services rendered by providers in this group other than those itemized above	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
	All of the following Report Items refer to Services rendered by other providers at the order of prescription of providers in this group to recipients with primary coverage under Title XIX.		X	
6Ø	No. Services-Other Physicians	Total number of services rendered by other physicians		X
61	Pmts. for Svce.-Other Physicians	Total dollars paid for services rendered by other physicians		X
62	No. Services-Out Hosp.	Total number of services rendered by outpatient hosp.		X
63	Pmts. for Svcs.-Out Hosp.	Total dollars paid for services rendered by outpatient hospital		X
64	No. Svcs.-Lab. & X-Ray	Total number of services rendered by independent laboratory and X-Ray organizations		X
65	Pmts. for Svcs.-Lab & X-Ray	Total dollars paid for services rendered by independent laboratory and X-Ray organizations		X
66	No. Hosp. Discharges	Total number of inpatient hospital discharges		X
67	Pmts. for In Hosp. Services	Total dollars paid for inpatient hospital services		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
68	Days of Hospital Stay	Total days of stay in hospitals		X
69	No. Hosp. Surg. Dscgs.	Total number of inpatient hospital discharges after surgery		X
7Ø	Days of Preop. Hospital Stay	Total days of preoperative stay in hospitals		X
71	No. Patients in LTCF	Total number of patients residing in long term care facilities		X
72	No. of LTCF Discharges	Total number of discharges from long term care facilities		X
73	Pmts. for LTCF Services	Total dollars paid for services of long term care facilities		X
74	No. of Drug Rx Filled	Total number of drug prescriptions filled		X
75	Pmts. for Drug Rx	Total dollars paid for drug prescriptions filled		X
76	No. All Other Services Ordered	Total number of all other services rendered at the order of providers in this group		X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-O-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
77	Pmts. for all Other Services	Total dollars paid for all other services rendered at the order of providers in this group		X
	Each of the following Report Items is reported for the immediately proceeding twelve month period and refers to services rendered to recipients with primary coverage under Title XIX.			
78	Max. Visits in 1 Day-Total	A count of the maximum number of Medical Visits by providers in this group in a single day		X
79	Max. Visits in 1 Day-In Hosp.	A count of the maximum number of Medical Visits by providers in this group in a single day at inpatient hospitals		X
8Ø	Max. Visits in 1 Day-LTCF	A count of the maximum number of Medical Visits at long term care facilities by providers in this group in a single day		X
81	Max. Visits in 1 Day-Office	A count of the maximum number of Medical Visits by providers in this group at their offices in a single day		X

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
82	Max. Visits in 1 Day-Home	A count of the maximum number of Medical Visits at patients' homes by providers in this group in a single day		X
CC	Averages Section	Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve month, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change Value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Physician Services. The values of each Report Item, however, are for an average provider in this Class Group rather than for a specific provider.	X	
DD	Standard Deviations Section	Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service Basis. A Trend Line Rate of change value covering the last fifteen months is also reported for each Report Item.	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN CLASS PROFILES SU-0-Ø2

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
		The Report Item content of this Section is identical to that of the Summary Profile Report-Physician Services. The values of each Report Item, however, represent the standard deviation from the average of the corresponding values of all individual providers in this Class Group.		
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Physician Services may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers in this Class Group fell into each value range.		X

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report- Inpatient Hospital Services Class Profiles	SU-O-Ø3
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Management Summary Module Process Step U2.1	Monthly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Inpatient Hospital Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provice management and administrative personnel with a detailed breakout of the overall utilization patterns of Inpatient Hospitals.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Inpatient Hospital Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-INPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø3

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
AA	Identification Section		
Ø1	Category of Service	Category of Service Code (Data Element 3Ø1)	X
Ø2	Class Group	Class Group Code (Date Element 7Ø2)	X
B1	Totals Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item.		X
Ø1	Dollars Invoiced-Medicaid	Total dollars invoiced for services rendered by providers in this group under Title XIX	X
Ø2	Dollard Paid-Medicaid	Total dollars paid to providers in this group for services rendered under Title XIX	X
Ø3	Dollars Paid-Medicare	Total dollars paid to providers in this group by Title XIX for Title XVIII Coinsurance and Deductible	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-INPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø3

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø4	Total Dollars Paid	Total dollars paid to providers in this group by Title XIX	X	
Ø5	No. Recipients Served-Medicaid	An unduplicated count of individual recipients with primary coverage under Title XIX served by providers in this group	X	
Ø6	No. Recipients Served-Medicare	An unduplicated count of individual recipients with primary coverage under Title XVIII served by providers in this group.	X	
Ø7	Total No. Recipients Served	An unduplicated count of all individual recipients served by providers in this group	X	
Ø8	No. of Admissions	A count of individual admissions	X	
Ø9	No. of Discharges	A count of all individual discharges	X	
1Ø	No. of Days Preop. Stay	Total days of preoperative stay	X	
11	No. of Surg. Discharges	A count of individual discharges after surgery	X	
12	Discharges 1 Day	Number of discharges after 1 day of stay	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-INPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø3

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
13	Discharges 2 Days	Number of discharges after 2 days of stay	X
14	Discharges 3-5 Days	Number of discharges after 3-5 days of stay	X
15	Discharges 6-8 Days	Number of discharges after 6-8 days of stay	X
16	Discharges 9-15 Days	Number of discharges after 9-15 days of stay	X
17	Discharges 16-30 Days	Number of discharges after 16-30 days of stay	X
18	Discharges 31 Days Up	Number of discharges after more than 30 days of stay	X
19	Discharges w/Surgery	Number of discharges with surgery	X
2Ø	Discharges to NH	Number of discharges to nursing homes	X
21	Discharges to Home Care	Number of discharges to home health care	X
22	No. of Fri.-Sat. Admissions	Number of Friday and Saturday admissions	X
23	No. of Sun.-Mon. Discharges	Number of Sunday and Monday discharges	X

SUBSYSTEM MARS MANAGEMENT SUNNARY REPORT-INPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø3

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
24	No. of Ancillaries	Number of ancillary services rendered	X	
25	Pmts. for Ancillaries	Total dollars paid for ancillary services	X	
26	No. of Admis. Prior Auth.	Number of admissions with prior authorization		X
Bx	(General Type of Service) Totals Section	There may be up to eight sections of this type, where x is the section number (2-9) and General Type of Service describes a grouping of Service types, e.g., Medical, Pediatrics, etc. Each of these sections has the same Report Item content as Section B1. The values of each Report Item apply only to the General Type of Service under consideration.		
CC	Averages Section	Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Physician Services. The values of each Report Item, however, are for an average provider in this Class Group rather than for a specific provider.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-INPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø3

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
DD		Standard Deviation Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item Content of this section is identical to that of the Summary Profile Report Inpatient Hospital Services. The values of each Report Item, however, represent the standard deviation from the average of the corresponding values of all individual providers in this Class Group.	X	
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Inpatient Hospital Services may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers in this Class Group fell into each value range.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Profile Outpatient Hospital Services Class Profiles	SU-O-Ø4
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Management Summary Module Process Step U2.1	Monthly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Outpatient Hospital Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of Outpatient Hospitals.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Outpatient Hospital Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-OUTPATIENT HOSPITAL SERVICES CALSS PROFILES SU-O-Ø4

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
AA	Identification Section		
Ø1	Category of Service	Category of Service Code (Data Element 3Ø1)	X
Ø2	Class Group	Class Group Code (Data Element 7Ø2)	X
B1	Totals Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item.		X
Ø1	Dollars Invoiced-Medicaid	Total dollars invoiced for services rendered by providers in this group under Title XIX.	X
Ø2	Dollars Paid-Medicaid	Total dollars paid to providers in this group for services rendered under Title XIX.	X
Ø3	Dollars Paid-Medicare	Total dollars paid to providers in this group by Title XIX for Title XVIII Coinsurance and Deductible	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-OUTPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø4

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
Ø4	Total Dollars Paid	Grand total dollars paid to providers in this group by Title XIX	X
Ø5	No. Recipients Served-Medicaid	An unduplicated count of individual recipients with primary coverage under Title XIX served by providers in this group	X
Ø6	No. Recipients Served Medicare	An unduplicated count of individual recipients with primary coverage under Title XVIII served by providers in this group	X
Ø7	Total No. Recipients Served	An unduplicated count of all individual recipients served by providers in this group	X
Ø8	No. of Services Provided	A count of all specific, individual services rendered by providers in this group	X
Ø9	No. of Services Prior Auth.	Number of services prior authorized	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-OUTPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø4

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Bx		(General Type of Service) Totals Section There may be up to eight sections of this type, where x is the section number (2-9) and General Type of Service describes a grouping of service types, e.g., Surgery, Pharmacy, Emergency Room, etc. Each of these sections has the same Report Item content as Section B1. The values or each Report Item apply only to the General Type of Service under consideration.		X
CC		Averages Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, and on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Outpatient Hospital Services. The values of each Report Item, however, are for an average provider in this Class Group rather than for a specific provider.	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-OUTPATIENT HOSPITAL SERVICES CLASS PROFILES SU-O-Ø4

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
DD		Standard Deviations Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Outpatient Hospital Services. The values of each Report Item, however, represent the standard deviation from the average of the corresponding values of all individual providers in this Class Group.	X	
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Outpatient Hospital Services may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers in this Class Group fell into each value range.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report Long Term Care Facility Services Class Profiles	SU-O-Ø5
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Management Summary Module Process Step U2.1	Monthly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Long Term Care Facility Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of Long Term Care Facilities.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Long Term Care Facility Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-LONG TERM CARE FACILITY SERVICES CLASS PROFILES SU-0-Ø5			
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
AA	Identification Section		
Ø1	Category of Service	Category of Service Code (Date Element 3Ø1)	X
Ø2	Class Group	Class Group Code (Date Element 7Ø2)	X
B1	Totals Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line of Change value covering the last fifteen months is also reported for each Report Item.		X
Ø1	Dollars Invoiced-Medicaid	Total dollars invoiced for services rendered by providers in this group under Title XIX	X
Ø2	Dollars Paid-Medicaid	Total dollars paid to providers in this group for services rendered under Title XIX	X
Ø3	Dollars Paid-Medicare	Total dollars paid to providers in this group by Title XIX for Title XVIII Coinsurance and Deductible	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-LONG TERM CARE FACILITIES SERVICES CLASS PROFILES SU-O-Ø5

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø4	Total Dollars Paid	Grand total dollars paid to providers in this group by Title XIX	X	
Ø5	No. Recipients Served-Medicaid	An unduplicated count of individual recipients with primary coverage under Title XIX served by providers in this group	X	
Ø6	No. Recipients Served-Medicare	An unduplicated count of individual recipients with primary coverage under Title XVIII served by providers in this group	X	
Ø7	Total No. Recipients Served	An unduplicated count of all individual recipients served by providers in this group	X	
Ø8	No. of Recipients in Category	Number of recipients in this patient status category	X	
Ø9	No. of Recipients 1-3Ø Days	Number of recipients with 1 to 3Ø days of stay	X	
1Ø	No. of Recipients 31-6Ø Days	Number of recipients with 31 to 6Ø days of stay	X	
11	No. of Recipients 61-9Ø Days	Number of recipients with 61 to 9Ø days of stay	X	
12	No. of Recipients 91-12Ø Days	Number of recipients with 91 to 12Ø days of stay	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION		
SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-LONG TERM CARE FACILITY SERVICES CLASS PROFILES SU-O-Ø5				
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
13	No. of Recipients 121-15Ø Days	Number of recipients with 121-15Ø days of stay	X	
14	No. of Recipients 151 Days Up	Number of recipients with 151 days of stay and over	X	
15	Total Days Stay	Total days of stay	X	
16	Total Leave Days	Total leave days	X	
17	No. Ancillaries	Total number of ancillaries services	X	
18	Pmts. for Ancillaries	Total payments for ancillary services	X	
19	No. of Recipients Prior Auth.	Number of recipients receiving prior authorization for service		X
Bx	Totals for (Patient Status Category) Section There may be three sections of this type, where x is Section number (2-4) and Patient Status Category is Resident, Discharged, or Deceased. Each of these sections has the same Report Item content as Section B1. The values of each Report Item apply only to the Patient Status Category under consideration.			X

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
CC		Averages Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Long Term Care Facility Services. The values of each Report Item, however, are for an average provider in this Class Group rather than for a specific provider.	X	
DD		Standard Deviations Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item Content of this section is identical to that of the Summary Profile Report-Long Term Care Facilities Services. The values of each Report Item, however, represent the standard deviation from the average of the corresponding values of all individual providers in this Class Group.	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-LONG TERM CARE FACILITY SERVICES CLASS PROFILES SU-O-Ø5

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL →	
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Long Term Care Facility Services may be selected. The Report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers in this Class Group fell into each value range.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report- Dental Services Class Profiles	SU-O-Ø6
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Management Summary Module	Monthly
Process Step U2.1	**MEDIA** Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Dental Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of Dental Services.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Dental Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-DENTAL SERVICES CLASS PROFILES SU-O-Ø6

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
AA	Identification Section		
Ø1	Category of Service	Category of Service Code (Data Element 3Ø1)	X
Ø2	Class Group	Class Group Code (Data Element 7Ø2)	X
B1	Totals Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date, and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item.		X
Ø1	Dollars Invoiced-Medicaid	Total dollars invoiced for services rendered by providers in this group under Title XIX	X
Ø2	Dollars Paid-Medicaid	Total dollars paid to providers in this group for services rendered under Title XIX	X
Ø3	Dollars Paid-Medicare	Total dollars paid to providers in this group by Title XIX for Title XVIII Coinsurance and Deductible	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-DENTAL SERVICES CLASS PROFILES SU-O-Ø6

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø4	Total Dollars Paid	Grand total dollars paid to providers in this group by Title XIX		
Ø5	No. Recipients Served-Medicaid	An unduplicated count of individual recipients with primary coverage under Title XIX served by providers in this group	X	
Ø6	No. Recipients Served-Medicare	An unduplicated count of individual recipients with primary coverage under Title XVIII served by providers in this group	X	
Ø7	Total No. Recipients Served	An unduplicated count of all individual recipients served by providers in this group	X	
Ø8	No. of Services Provided	A count of individual services rendered by providers in this group	X	
Ø9	No. of Services Prior Auth.	Total number of services with prior authorization.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-DENTAL SERVICES CLASS PROFILES SU-O-Ø6

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Bx		(General Type of Service) Totals Section There may be up to eight sections of this type, where x is the section number (2-9) and General Type of Service describes a grouping of services types, e.g. Exam, Extraction, etc. Each of these sections has the same Report Item content as Section B1. The values of each Report Item apply only to the General Type of Service under consideration.	X	
CC		Averages Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Dental Services. The values of each Report Item, however, are for an average provider in this Class Group rather than for a specific provider.	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-DENTAL SERVICES CLASS PROFILES SU-O-Ø6

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
DD		Standard Deviations Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Dental Services. The values of each Report Item, however, represent the standard deviation from the average of the corresponding values of all individual providers in this Class Group.	X	
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Dental Services may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers in this Class Group fell into each value range.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report- Prescribed Drugs Class Profiles	SU-O-Ø7
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Management Summary Module Process Step U2.1	Monthly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Prescribed Drug Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of Prescribed Drugs.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Prescribed Drugs Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PRESCRIBED DRUGS CLASS PROFILES SU-O-Ø7

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
AA	Identification Section		
Ø1	Category of Service	Category of Service Code (Data Element 3Ø1)	X
Ø2	Class Group	Class Group Code (Data Element 7Ø2)	X
B1	Totals Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item.		X
Ø1	Dollars Invoiced-Medicaid	Total dollars invoiced for services rendered by providers in this group	X
Ø2	Dollars Paid-Medicaid	Total dollars paid to providers in this group for services rendered under Title XIX	X
Ø3	Dollars Paid-Medicare	Total dollars paid to providers in this group by Title XIX for Title XVIII Coinsurance and Deductible	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PRESCRIBED DRUGS CLASS PROFILES SU-O-Ø7

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø4	Total Dollars Paid	Grand Total dollars paid to providers in this group by Title XIX	X	
Ø5	No. Recipients Served-Medicaid	An unduplicated count of individual recipients with primary coverage under Title XIX served by providers in this group	X	
Ø6	No. Recipients Served-Medicare	An unduplicated count of individual recipients with primary coverage under Title XVIII served by providers in this group	X	
Ø7	Total No. Recipients Served	An unduplicated count of all individual recipients served by providers in this group	X	
Ø8	No. of Rx Filled	A count of individual prescriptions filled by providers in this group	X	
Ø9	No. of Refill Rx	Total number of refill prescriptions	X	
1Ø	No. of Compounded Rx	Total number of compounded prescriptions	X	
11	No. of OTC Rx	Total number of over-the-counter prescriptions	X	

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
12	Pmts. for Prof. Fee	Total payments for professional fees.	X	
13	No. of Rx Prior Authorized	Total number of prescriptions prior authorized	X	
Bx		(General Drug Category) Totals Section There may be up to eight sections of this type, where x is the section number (2-9) and General Drug Category describes a grouping of drugs, e.g., Antibiotic, Narcotic, etc. Each of these sections has the same Report Item Content as section B1. The values of each Report Item apply only to the General Drug Category under consideration.		X
CC		Averages Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Provile Report-Prescribed Drugs. The values of each Report Item, however, are for an average provider in this Class Group rather than for a Specific provider.	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PRESCRIBED DRUGS CLASS PROFILES SU-O-Ø7

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
DD		Standard Deviations Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Prescribed Drugs. The values of the Report Item, however, represent the standard deviation from the average of the corresponding values of all individual providers in this Class Group.	X	
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Prescribed Drugs may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers of this Class Group fell into each value range.		X

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report- Other Provider Class Profiles	SU-0-Ø8
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Management Summary Module Process Step U2.1	Monthly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each other provider Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakdown of the overall utilization patterns of all other providers.

REMARKS

One Class Profile, consisting of four sections, will be produced for each other provider Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION		
SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-OTHER PROVIDERS CLASS PROFILES SU-O-Ø8				
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
AA	Identification Section			
Ø1	Category of Service	Category of Service Code (Data Element 3Ø1)	X	
Ø2	Class Group	Class Group Code (Date Element 7Ø2)	X	
B1	Totals Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item.		X	
Ø1	Dollars Invoiced-Medicaid	Total dollars invoiced for services rendered by providers in this group under Title XIX	X	
Ø2	Dollars Paid-Medicaid	Total dollars paid to providers in this group for services rendered under Title XIX	X	
Ø3	Dollars Paid-Medicare	Total dollars paid to providers in this group for services rendered under Title XVIII (Coinsurance and Deductible)	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-OTHER PROVIDERS CLASS PROFILES SU-O-Ø8

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø4	Total Dollars Paid	Grand Total dollars paid to providers in this group by Title XIX	X	
Ø5	No. Recipients Served-Medicaid	An unduplicated count of individual recipients with primary coverage under Title XIX served by providers in this group	X	
Ø6	No. Recipients Served-Medicare	An unduplicated count of individual recipients with primary coverage under Title XVIII served by providers in this group	X	
Ø7	Total No. Recipients Served	An unduplicated count of all individual recipients served by providers in this group	X	
Ø8	No. of Services Provided	A count of all specific, individual services rendered by providers in this group	X	
Ø9	No. of Services Prior Auth	Number of services prior authorized		X

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
CC		Averages Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Other Providers. The values of each Report Item, however, are for an average provider in this Class Group rather than for a specific provider.	X
DD		Standard Deviations Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the twelve months, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report-Other Providers. The values of each Report Item, however, represent the standard deviation from the average of the corresponding values of all individual providers in this Class Group.	X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-OTHER PROVIDERS CLASS PROFILES SU-O-Ø8

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Other Providers may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers in this Class Group fell into each value range.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report- Physician Treatment Analysis Class Profiles	SU-O-Ø9
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Management Summary Module Process Step U2.3	Monthly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	Diagnosis Code
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Physician Treatment Analysis Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of Physician Services, by diagnosis code.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Physician Treatment Analysis Class Group previously defined. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION			REPORT ITEM DESCRIPTION	
SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN TREATMENT ANALYSIS CLASS PROFILES SU-O-Ø9				
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
AA	Identification Section			
Ø1	Category of Service	Category of Service Code (Date Element 3Ø1)	X	
Ø2	Class Group	Class Group Code (Data Element 7Ø2)	X	
Bx	Diagnosis Code Totals Each of the Report Items in this section refers to services rendered to recipients with primary coverage under Title XIX. The section is repeated once for each diagnosis code reported during the last twelve month period by the provider Class Group. Within each diagnosis code section there may be up to five additional iterations by age group for all Report Items listed below. The values of all Report Items reflect twelve months of activity.		X	
Ø1	Diagnosis Code	Data Element 3Ø6	X	
Ø2	Age Group Code	Data Element 7Ø6		X
Ø3	Number of Recipients	An unduplicated count of recipients for whom this diagnosis was reported	X	
Ø4	Number of Services	A count of services provided in response to this diagnosis code	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN TREATMENT ANALYSIS CLASS PROFILES SU-O-Ø9

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø5	No. of Different Procedures	An unduplicated count of individual procedures rendered in response to this diagnosis code	X	
Ø6	No. of Drug Rx	A count of drug prescriptions filled in response to this diagnosis code		X
Ø7	No. of Different Drugs	An unduplicated count of individual drugs prescribed in response to this diagnosis code		X
Ø8	No. of Hospital Discharges	A count of discharges after stays in inpatient hospitals under this diagnosis code		X
Ø9	No. of Days of Hospital Stay	Total number of days stay in inpatient hospitals		X
1Ø	Procedure Code	Data Element 5ØØ (This item occurs once for each individual procedure applied for this diagnosis)		X
11	Frequency of Procedure	Total number of times this procedure was applied for this diagnosis (This item occurs jointly with Procedure Code)		X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN TREATMENT ANALYSIS CLASS PROFILES SU-0-Ø9

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
12	Drug Code	Date Element 5Ø1 (This item occurs once for each individual drug prescribed for this diagnosis)		X
13	Frequency of Drug	Total number of times this drug was prescribed for this diagnosis (This item occurs jointly with Drug Code)		X
Cxx	Averages Section Each of the Report Items in this section refers to services rendered to recipients with primary coverage under Title XIX. The section is repeated once for each diagnosis code reported during the last twelve month period by the provider Class Group under consideration. Within each diagnosis code section there may be up to five additional iterations by age group for all Report Items contained herein. The Report Item content of this section is identical to that of the Treatment Analysis Report-Physician Services. The value of each Report Item, however, is for an average provider in this Class Group rather than for a specific provider.		X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-PHYSICIAN TREATMENT ANALYSIS CLASS PROFILES SU-O-Ø9

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
Dxx		Standard Deviations Section Each of the Report Items in this section refers to services rendered to recipients with primary coverage under Title XIX. The section is repeated once for each diagnosis code reported during the last twelve month period by the provider Class Group under consideration. Within each diagnosis code section there may be up to five additional iterations by age group for all Report Items contained herein. The Report Item content of this section is identical to that of the Treatment Analysis Report-Physician Services. The value of each Report Item, however, represents the standard deviation from the average of the corresponding value of all individual providers in this Class Group.	X	
Exx		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Treatment Analysis Report-Physician Services may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers of this Class Group fell into each value range.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report- Inpatient Hospital Treatment Analysis Class Profile	SU-O-1Ø
SUBSYSTEM NAME	**DATE**
Management and Administrative REporting	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Management Summary Module Process Step U2.3	Monthly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	Diagnosis Code
2.	Class Group	5.	
3.	Section Number	6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Inpatient Hospital Treatment Analysis Class Group by use of standard deviations and frequency distributions.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of Inpatient Hospital Services, by diagnosis code.

REMARKS

One Class Profile, consisting of four sections, will be produced for each other Inpatient Hospital Treatment Analysis Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-INPATIENT HOSPITAL TREATMENT ANALYSIS CLASS PROFILES SU-O-1Ø

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
AA	Identification Section			
Ø1	Category of Service	Category of Service Code (Data Element 3Ø1)	X	
Ø2	Class Group	Class Group Code (Data Element 7Ø2)	X	
Bxx	Diagnosis Code Totals Section	Each of the Report Items in this section refers to services rendered to recipients with primary coverage under Title XIX. The Section is repeated once for each diagnosis code reported during the last twelve month period by the provider Class Group. Within each diagnosis code section there may be up to five additional iterations by age group for all Report Items listed below. The values of all Report Items reflect twelve months of activity.		
Ø1	Diagnosis Code	Data Element 3Ø6	X	
Ø2	Age Group Code	Data Element 7Ø6		X
Ø3	No. of Surgical Discharges	A count of discharges after surgery for this diagnosis code	X	
Ø4	No. of Non-Surgical Discharges	A count of discharges with no surgery involved, for this diagnosis code	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-INPATIENT HOSPITAL TREATMENT ANALYSIS CLASS PROFILES SU-O-1Ø

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø5	No. of Days Surg. Stay	Total number of days of stay prior to discharges after surgery	X	
Ø6	No. of Days Non-Surg. Stay	Total number of days of stay prior to discharges not involving surgery	X	
Ø7	No. of Ancillaries with Surg:	Total number of ancillary services for stays involving surgery	X	
Ø8	No. of Ancillaries without Surg.	Total number of ancillary services for non-surgical stays	X	
Ø9	Ancillary Code	Data Element 5ØØ (This item occurs once for each individual ancillary provided for this diagnosis)		X
1Ø	Frequency of Ancillary	Total number of times this ancillary was provided for this diagnosis (This item occurs jointly with Ancillary Code)		X

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Cxx		Averages Section Each of the Report Items in this section refers to services rendered to recipients with primary coverage under Title XIX. The section is repeated once for each diagnosis code reported during the last twelve month period by the provider Class Group under consideration. Within each diagnosis code section there may be up to five additional iterations by age group for all Report Items contained herein. The Report Item content of this section is identical to that of the Treatment Analysis Report-Inpatient Hospital Services. The value of each Report Item, however, is for an average provider in this Class Group rather than for a specific provider.	X	
Dxx		Standard Deviations Section Each of the Report Items in this section refers to services rendered to recipients with primary coverage under Title XIX. The section is repeated once for each diagnosis code reported during the last twelve month period by the provider Class Group under consideration. Within each diagnosis code section there may be up to five additional iterations by age group for all Report Items contained herein. The Report Item content of this section is identical to that of the Treatment Analysis Report-Inpatient Hospital Services. The value of each Report Item, however, represents the standard deviation from the average of the corresponding value of all individual providers in this Class Group.	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-INPATIENT HOSPITAL TREATMENT ANALYSIS CLASS PROFILES SU-O-1Ø

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Exx		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Treatment Analysis Report-Inpatient Hospital Services may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual providers of this Class Group fell into each value range.		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Participation Summary	MR-0-22
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Recipient Module Process Step M5.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Administration (Level II)
2.	Recipient Relations (Level II)
3.	Provider Relations (Level II)
4.	Operations (Level II)
5.	

SEQUENCE

1.	Aid Category	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To present an overview of recipient participation and utilization of services by listing key information concerning payments and number of recipients. The information is presented by time periods and reflects the current trend of activity.

REMARKS

RUN DATE 6/30/72

MONTH OF JUNE

RECIPIENT PARTICIPATION SUMMARY

AID CATEGORY		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	TREND	FISCAL YEAR-TO-DATE THIS YEAR	FISCAL YEAR-TO-DATE LAST YEAR
AGED							
NUMBER OF ELIGIBLE RECIPIENTS	(22.01)	72,360	71,420	72,104	+.001	76,072	75,541
NUMBER OF ELIGIBLE RECIPIENTS PARTICIPATING	(22.02)	41,610	40,812	40,962	+.001	66,989	63,590
PERCENT PARTICIPATING	(22.03)	57.5 %	57.1 %	56.8 %	+.001	88.1 %	84.2 %
NUMBER OF MEDICALLY NEEDY PARTICIPATING	(22.04)	1,480	1,004	1,360	+.001	3,460	3,140
TOTAL TITLE XIX PAYMENTS	(22.05)	1,828,698	1,638,169	1,801,422	+.002	16,479,287	15,399,962
AVG. PAYMENT PER ELIG RECIP	(22.06)	43.95	40.14	43.98	+.000	246.00	234.20
AVG. DAYS FROM DATE OF APPLICATION TO MEDICAID CERTIFICATION	(22.07)	16	20	17	-.001	16	19

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-22

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM: MARS Recipient Participation Summary — MR-O-22

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
22.01	Number of Eligibles	An unduplicated count of the number of individuals eligible for Medicaid during the time period shown.	X	
22.02	Number of Eligibles Participating	An unduplicated count of the number of eligible individuals receiving Medicaid benefits during the time period shown.	X	
22.03	Percent Participating	The percent of eligible individuals that received Medicaid benefits during the time period shown (22.02 ÷ 22.01 x 100).	X	
22.04	Number of Medically Needy Participating	The number of medically needy participants receiving Medicaid benefits that would have qualified for the aid category shown had their incomes been lower.	X	
22.05	Total Title XIX Payments	The total Medicaid expenditures for categorically and medically needy recipients in the aid category shown.	X	
22.06	Average Payment Per Eligible Recipient	The average Medicaid expenditure per participating recipient (22.05 ÷ 22.02).	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Recipient Participation Summary	MR-O-22

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
22.07	Average Days from Date of Application to Medicaid Certification	The average elapsed days from the date of application for Medicaid benefits to the date eligibility certification is recorded on the Medicaid eligibility records for the recipients added to the eligibility roles during the time period shown.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
County Participation Analysis	MR-0-23
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Recipient Module Process Step M5.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations (Level III)
2.	Provider Relations (Level III)
3.	County Office
4.	
5.	

SEQUENCE

1.	County	4.	
2.	Aid Category	5.	
3.		6.	

PURPOSE OF OUTPUT

To determine the degree of participation by recipients in selected geographic areas. This report will enable program management to monitor the impact at the county level of the availability of Title XIX services and to initiate whatever action is required.

REMARKS

MONTH OF JUNE

COUNTY PARTICIPATION ANALYSIS

COUNTY: ANY COUNTY	ELIGIBLE RECIPIENTS	PARTICIPATING RECIPIENTS	PERCENT PARTICIPATING	PAYMENT PER ELIGIBLE RECIPIENT
CATEGORICALLY NEEDY (MONEY PAYMENT)				
AGED	4,404	3,511	79.7 %	36.40
BLIND	103	76	73.8 %	37.67
DISABLED	1,734	1,225	70.6 %	33.78
AFDC CHILDREN	2,416	821	34.0 %	14.46
AFDC ADULTS	17	15	88.2 %	93.06
TOTAL	8,674	5,648	65.1 %	29.89
CATEGORICALLY NEEDY (NO MONEY PAYMENT)				
AGED	199	181	91.0 %	322.14
BLIND	1	1	100.0 %	.13
DISABLED	21	14	66.7 %	191.10
AFDC CHILDREN	154	57	37.0 %	21.97
AFDC ADULTS	1,345	1,065	79.2 %	24.76
OTHER XIX CHILDREN	8	4	50.0 %	48.63
TOTAL	1,728	1,322	76.5 %	60.88
MEDICALLY NEEDY				
AGED	132	128	97.0 %	52.84
BLIND	3	0	.0 %	.00
DISABLED	51	45	88.2 %	42.55
AFDC-RELATED CHILDREN	80	56	70.0 %	25.00
AFDC-RELATED ADULTS	15	11	73.3 %	9.47
OTHER XIX CHILDREN UNDER 21	8	0	.0 %	.00
OTHER XIX ADULTS 21-64	5	0	.0 %	.00
TOTAL	294	240	81.6 %	38.36
TOTAL RECIPIENTS	10,696	7,210	67.4 %	35.13
OTHER RECIPIENTS	(23.01)	(23.02)	(23.03)	(23.04)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-23

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS County Participation Analysis	MR-0-23

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
23.01	Eligible Recipients	An unduplicated count of the number of recipients in the county eligible for Medicaid during the month in the aid category indicated.	X	
23.02	Participating Recipients	An unduplicated count of the number of recipients in the county receiving one or more units of Medicaid service during the month.	X	
23.03	Percent Participating	The number of recipients participating expressed as a percent of the number of eligible recipients.	X	
23.04	Payment Per Eligible Recipient	The total of all payments made on behalf of participating recipients divided by the number of eligible recipients.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
County Expenditure Analysis	MR-0-24
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Recipient Module Process Step M5.2	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Administration (Level III)
2.	Recipient Relations (Level III)
3.	County Offices
4.	
5.	

SEQUENCE

1.	County	4.	
2.	Category of Service	5.	
3.	Aid Category	6.	

PURPOSE OF OUTPUT

To provide financial participation data to assist in planning and controlling program cost. The number of claims and payment amounts are presented by county for Aid Categories within each Category of Service.

REMARKS

RUN DATE 6/30/72

MONTH OF JUNE

COUNTY EXPENDITURE ANALYSIS

COUNTY: ANY COUNTY

	INPATIENT		PHYSICIAN		NURSING HOME		PHARMACY		OTHER		TOTAL	
	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS
CATEGORICALLY NEEDY (MONEY PAYMENT)												
AGED	117	29,073	1,715	28,542	203	65,231	8,168	31,433	379	6,028	10,582	160,307
BLIND	4	1,186	70	1,165			333	1,283	15	246	422	3,880
DISABLED	73	17,215	1,074	17,882			5,117	19,694	237	3,777	6,501	58,568
AFDC CHILDREN	43	10,679	630	10,485			3,000	11,547	139	2,214	3,812	34,925
AFDC ADULTS	2	1,180	11	170			52	194	5	38	70	1,582
TOTAL	239	59,333	3,500	58,244	203	65,231	16,670	64,151	775	12,303	21,387	259,262
CATEGORICALLY NEEDY (NO MONEY PAYMENT)												
AGED	67	11,508	678	11,298	82	26,470	3,233	12,443	150	2,386	4,210	64,105
BLIND							3	13			3	13
DISABLED	7	1,227	72	1,205			344	1,327	16	254	439	4,013
AFDC CHILDREN	6	1,035	61	1,016			290	1,119	13	214	370	3,384
AFDC ADULTS	60	10,184	600	9,998			2,861	11,011	132	2,111	3,653	33,304
OTHER XIX CHILDREN	2	123	9	120			33	119	3	27	47	389
TOTAL	142	24,077	1,420	23,637	82	26,470	6,764	26,032	314	4,992	8,722	105,208
MEDICALLY NEEDY												
AGED	35	1,265	75	1,242	10	2,838	356	1,367	17	263	493	6,975
BLIND												
DISABLED	1	370	47	778			223	857	11	165	282	2,170
AFDC-RELATED CHILDREN	26	946	28	456			131	502	6	96	191	2,000
AFDC-RELATED ADULTS			3	58			16	64	1	12	20	142
OTHER XIX CHILDREN UNDER 21												
OTHER XIX ADULTS 21-64												
TOTAL	62	2,581	153	2,534	10	2,838	726	2,790	35	536	1,016	11,279
TOTAL XIX RECIPIENTS	443	85,991	5,073	84,421	295	94,539	24,160	92,973	1,124	17,831	31,125	375,755
OTHER RECIPIENTS												
	(24.01)	(24.02)										

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-24

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS County Expenditure Analysis	MR-O-24

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
24.01	Claims	The number of claims for the category of service and aid category indicated for which a Medicaid payment was made during the month.	X
24.02	Dollars	The total amount of the Medicaid payments made during the month for the category of service and aid category indicated.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Benefit Usage Analysis	MR-0-25
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Recipient Module Process Step M5.3	Annual
	MEDIA
	Stock Paper

DISTRIBUTION

1. Recipient Relations (Level III)
2.
3.
4.
5.

SEQUENCE

1.	Aid Category	4.	
2.	Category of Service	5.	
3.		6.	

PURPOSE OF OUTPUT

To provide planning and control information by reviewing the utilization of recipient benefits with respect to limits for services having such limitations. Information is presented which analyzes the number of recipients and service units by Aid Category and Categories of Service.

REMARKS

RUN DATE 6/30/72

BENEFIT USAGE ANALYSIS

AID CATEGORY - AGED		INPATIENT	OUTPATIENT	NURSING HOMES	PHYSICIAN SERVICES	LAB AND X-RAY	PRESC. DRUGS	HOME HEALTH	PERIODIC SCREEN	OTHER
SERVICE LIMITS	(25.01)	10 DAYS	5 VISITS	365 DAYS	20 VISITS	NONE	NONE	NONE	N/A	NONE
NUMBER OF ELIGIBLE RECIPIENTS	(25.02)	41,000	41,000	41,000	41,000	41,000	41,000	41,000	N/A	41,000
NUMBER OF PARTICIPATING RECIPIENTS	(25.03)	38,400	36,700	9,540	40,610	32,000	39,700	21,600	N/A	15,300
AVG. SERVICE UNITS PER ELIGIBLE RECIPIENT	(25.04)	5.0	4.2	228	10.3	5.2	12.1	2.1	N/A	4.6
AVG. SERVICE UNITS PER PARTICIPATING RECIPIENT	(25.05)	8.0	7.1	368	14.6	9.0	14.2	6.1	N/A	9.5
PERCENT OF ELIGIBLE RECIPIENTS UTILIZING -										
MAXIMUM BENEFITS	(25.06)	10	8	65	46	N/A	N/A	N/A	N/A	N/A
75-99 % OF MAXIMUM	(25.07)	30	52	15	26	N/A	N/A	N/A	N/A	N/A
50-74 % OF MAXIMUM		20	30	10	18	N/A	N/A	N/A	N/A	N/A
25-49 % OF MAXIMUM		35	10	5	8	N/A	N/A	N/A	N/A	N/A
0-24 % OF MAXIMUM		5	0	5	2	N/A	N/A	N/A	N/A	N/A

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-25

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM MARS Benefit Usage Analysis		MR-O-25	
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
25.01	Service Limits	The restrictions on utilization of benefits that may be applied by a State Medicaid Program. For example, a recipient might be limited to ten inpatient days of stay per year.	X
25.02	Number of Eligible Recipients	An unduplicated count of the number of recipients eligible for Medicaid benefits in the time period covered by the report.	X
25.03	Number of Participating Recipients	An unduplicated count of the number of recipients receiving Medicaid benefits in the time period covered by the report.	X
25.04	Average Service Units Per Eligible Recipient	The total units of service provided in each category divided by the number of eligible recipients.	X
25.05	Average Services/ Participating Recipients	The total units of service provided in each category divided by the number of recipients receiving benefits.	X
25.06	Percent of Eligible Recipients Utilizing Maximum Benefits	The number of recipients that received the maximum benefits available in a category of service divided by the number of eligible recipients.	X

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
25.07	Percent of Eligible Recipients Utilizing 75-99% of Maximum, 50-74% of Maximum, 25-49% of Maximum, 0-24% of Maximum.	The number of recipients receiving benefits in each of the ranges shown above are accumulated. For example, recipients receiving 16-19 physician visits, upon which there is a 20 visit maximum, would be counted as receiving 75-99% of maximum available benefits. The number of recipients counted in each range is divided by the number of eligible recipients to obtain the value of the report item.	X	

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Drug Usage by Eligibility Classification	MR-0-26
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Recipient Module Process Step M5.3	Annual
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations (Level III)
2.	Provider Relations (Level III)
3.	
4.	
5.	

SEQUENCE

1.	Drug Classification Code	4.	
2.	Aid Category	5.	
3.		6.	

PURPOSE OF OUTPUT

This report presents drug usage data by Aid Category and compares the number of recipients and dollar usage among categories for each Drug Classification Code. The report is intended to assist program planning and control.

REMARKS

RUN DATE 6/30/72

PAGE NO 01

DRUG USAGE BY ELIGIBILITY CLASSIFICATION

DRUG CLASS	AID CATEGORY	NUMBER OF RECIPIENTS	DOLLAR AMOUNT OF USAGE	PERCENT OF USAGE BY AID CATEGORY
01	AGED	24,670	82,360	22.8%
	BLIND	9,640	35,410	9.3%
	DISABLED	14,320	41,460	10.2%
	AFDC	41,210	105,470	32.2%
	MN	10,360	39,372	8.5%
	OTHER	4,760	20,210	7.0%
(26.01)	(26.02)	(26.03)	(26.04)	(26.05)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-26

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Drug Usage By Eligibility Classification	MR-O-26

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
26.01	Drug Class	A grouping of drugs that have similar therapeutic qualities. Examples of therapeutic classifications are antihistamines, tranquilizers, and diuretics (D.E. 5Ø9).	X	
26.02	Aid Category		X	
26.03	Number of Recipients	An unduplicated count of recipients, by aid category, that received one or more drugs in the therapeutic classification shown.	X	
26.04	Dollar Amount of Usage	The Medicaid expenditure, by aid category, for drugs in the therapeutic classification shown.	X	
26.05	Percent of Usage by Aid Category	Each aid category's percent of the total Medicaid expenditure for drugs in the therapeutic classification shown.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Periodic Screening Cost Analysis	MR-O-27
SUBSYSTEM NAME	**DATE**
Management and Reporting Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Recipient Module Process Step M5.3	Annually
	MEDIA
	Paper

DISTRIBUTION

1. Recipient Relations (Level III)
2. Administration (Level III)
3.
4.
5.

SEQUENCE

1.	Age Group	4.	
2.	County	5.	
3.		6.	

PURPOSE OF OUTPUT

To provide a comparison by county of the dollar cost of treating children who have been screened versus comparable children who have not been screened.

REMARKS

RUN DATE 6/30/72

PERIODIC SCREENING COST ANALYSIS

CHILDREN AGE : 6 TO 9 (27.01)

COUNTY NUMBER	CHILDREN WHO HAVE BEEN SCREENED			CHILDREN WHO HAVE NOT BEEN SCREENED		
	TOTAL CHILDREN	TOTAL CLAIM COST	AVERAGE COST	TOTAL CHILDREN	TOTAL CLAIM COST	AVERAGE COST
01	1,456	$512,512	$352.00	1,023	$392,832	$384.00
02	2,065	$683,515	$331.00	879	$402,582	$458.00
STATE TOTAL	145,661	$71,228,229	$489.00	38,078	$20,409,808	$536.00
(27.02)	(27.03)	(27.04)	(27.05)	(27.06)	(27.07)	(27.08)

VII-234.1

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-27

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Periodic Screening Cost Analysis	MR-O-27

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
27.01	Recipient Age Group	The recipient's age (the report date less D.E. 1Ø5) presented in meaningful groupings.	X	
27.02	County Number	Recipient County Code (D.E. 1Ø8)	X	
27.03	Total Children - Screened	An unduplicated count of all children who have been screened under the Early and Periodic Screening, Diagnosis and Treatment program.	X	
27.04	Total Claim Cost - Screened	The total annual cost of treatment services for those children who have been screened.	X	
27.05	Average Cost - Screened	The average annual cost per child (who has been screened) of treatment services, calculated by dividing total claim cost by number of children.	X	
27.06	Total Children - Not Screened	An unduplicated count of all AFDC children eligible for screening who have not been screened.	X	
27.07	Total Claim Cost - Not Screened	The total annual cost of treatment services for those children who have not been screened.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Periodic Screening Cost Analysis	MR-O-27

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
27.08	Average Cost - Not Screened	The average annual cost per child (who has not been screened) of treatment services, calculated by dividing total claim cost by number of children.	X

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Cost Sharing Summary	MR-O-28
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Recipient Module Process Step M5.3	Annually
	MEDIA
	Paper

DISTRIBUTION

1.	Administrative (Level III)
2.	
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

To provide a summary of recipient cost sharing contributions. This report will be helpful in determining the effect of recipient cost sharing upon utilization of services. Caution should be used in comparing average claim costs for those recipients with cost sharing requirements versus costs for recipients without cost sharing as the medical needs of the population groups may be different.

REMARKS

Since cost sharing requirements can differ greatly from State to State, this report must be tailored to an individual State plan during detail design.

RUN DATE 6/30/74

RECIPIENT COST SHARING SUMMARY

CATEGORY OF SERVICE	CATEGORICALLY NEEDY NUMBER CLAIMS	CATEGORICALLY NEEDY COST SHARING AMTS TOTAL	CATEGORICALLY NEEDY COST SHARING AMTS AVERAGE	CATEGORICALLY NEEDY AVERAGE CLAIM PMT	CATEGORICALLY NEEDY AVERAGE CLAIM COST	MEDICALLY NEEDY NUMBER CLAIMS	MEDICALLY NEEDY COST SHARING AMTS TOTAL	MEDICALLY NEEDY COST SHARING AMTS AVERAGE	MEDICALLY NEEDY AVERAGE CLAIM PMT	MEDICALLY NEEDY AVERAGE CLAIM COST
INPATIENT	30,385	--	--	289.00	289.00	4,261	138,630.00	30.00	281.00	311.00
PHYSICIAN	318,411	--	--	31.50	31.50	25,401	69,852.75	2.75	29.00	31.75
DRUG	678,942	--	--	4.50	4.50	75,618	37,809.00	.50	4.00	4.50
PHYSICAL THERAPY	15,801	39,502.50	2.50	15.50	18.00	3,851	7,702.00	2.00	17.00	19.00
CHIROPRACTOR	32,565	97,695.00	3.00	21.50	24.50	7,898	31,592.00	4.00	23.00	27.00
TOTAL	1,076,104	137,197.50				117,029	285,585.75			

(28.01)	(28.02)	(28.03)	(28.04)	(28.05)	(28.06)
PREMIUMS COLLECTED			1,612,821.00		(28.07)
TOTAL DEDUCTIBLE AND COPAYMENTS			422,783.25		(28.08)
TOTAL COST SHARING CONTRIBUTION			2,035,604.25		(28.09)

REPORT FORMAT SAMPLE

OUTPUT NO. MR-O-28

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Recipient Cost Sharing Summary	MR-O-28

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
28.01	Category of Service	Description of Data Element 3Ø1.	X
28.02	Number Claims	The number of claims received for the associated category of service.	X
28.03	Cost Sharing Amounts--Total	The total deductible, copayment, or coinsurance collected from the recipient (if any) for the category of service.	X
28.04	Cost Sharing Amounts--Average	The average cost sharing contribution for each claim (Item 28.03 divided by Item 28.02).	X
28.05	Average Claim Payment	The average claim payment by Medicaid.	X
28.06	Average Claim Cost	The average claim reimbursement to the provider including the recipient cost sharing contribution.	X
28.07	Premiums Collected	The total premiums collected from medically needy Medicaid recipients as a requirement for participation in the program.	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION
SUBSYSTEM MARS Recipient Cost Sharing Summary	MR-O-28

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
28.08	Total Deductible & Copayments	The total deductible, copayments, and coinsurance amounts, both categorically and medically needy, contributed by the recipients.	X	
28.09	Total Cost Sharing Contribution	The sum of 28.07 and 28.08.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Management Summary Report-Recipient Class Profiles	SU-O-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Management Summary Module Process Step U2.2	Quarterly
	MEDIA
	Paper

DISTRIBUTION

1.	Surveillance and Utilization Review Unit
2.	Management and Administrative Reporting Subsystem
3.	
4.	
5.	

SEQUENCE

1.	Class Group	4.	
2.	Section Number	5.	
3.		6.	

PURPOSE OF OUTPUT

1. To verify the statistical validity of each Recipient Class Group by use of frequency distributions and standard deviations.
2. To aid in the establishment of realistic Exception Control Limits where system generated limits are not acceptable.
3. To provide management and administrative personnel with a detailed breakout of the overall utilization patterns of recipients.

REMARKS

One Class Profile, consisting of four sections, will be produced for each Recipient Class Group previously defined by the user. An overall profile, also consisting of four sections, will be produced for each Category of Service.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-RECIPIENT CLASS PROFILE			SU-O-Ø1
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL
AA	Identification Section		
Ø1	Class Group	Class Group Code (Date Element 7Ø2)	X
BB	Totals Section Each of the Report Items in this section is reported for the following time periods: Average Month of the past twelve months, and each of the last five quarters, all on a Date of Service basis.		X
Ø1	Dollars Paid-Medicaid	Total dollars paid for services to recipients in this group rendered under Title XIX	X
Ø2	Dollars Paid-Medicare	Total dollars paid for services to recipients in this group rendered under Title XVIII (Coinsurance and Deductible)	X
Ø3	Total Dollars Paid	Item BB.Ø1+ Item BB.Ø2	X
	All of the following Report Items refer to services paid for entirely by Title XIX.		X
Ø4	No. Different Diagnoses	An unduplicated count of each separate primary diagnosis code reported for recipients in this group	X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-RECIPIENT CLASS PROFILES SU-0-Ø1

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
Ø5	No. Different Physicians	An unduplicated count of individual physicians, physician groups, or physician clinics seen by recipients in this group		X
Ø6	No. Medical Visits	Total number of all Medical Visits to physicians by recipients in this group	X	
Ø7	No. of Initial Visits	Total number of initial Medical Visits to physicians by recipients in this group	X	
Ø8	Pmts. for Medical Visits	Total dollars paid for Medical Visits to physicians by recipients in this group	X	
Ø9	No. of Injections	Total number of Injections received by recipients in this group	X	
1Ø	Pmts. for Injections	Total dollars paid for Injections received by recipients in this group		X
11	No. Surgical Procedures	Total number of Surgical Procedures received by recipients in this group	X	

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
12	Pmts. for Surgery	Total dollars paid for Surgical Procedures received by recipients in this group		X
13	No. Diag. Lab. Procedures	Total number of dollars paid for Diagnosis Laboratory Procedures received by recipients in this group	X	
14	Pmts. for Diag. Lab.	Total dollars paid for Diagnosis Laboratory Procedures received by recipients in this group		X
15	No. Diag. Rad. Procedures	Total number of Diagnostic Radiaology Procedures received by recipients in this group	X	
16	Pmts. for Diag. Rad.	Total dollars paid for Diagnostic Radiology Procedures received by recipients in this group		X
17	No. Hospital Discharges	Total number of times recipients in this group were discharged from inpatient hospitals	X	
18	No. Days in Hospital	Total number of days recipients in this group spent in inpatient hospitals	X	

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-RECIPIENT CLASS PROFILES SU-0-Ø1

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
19	No. Medical Visits-In Hosp.	Number of physician Medical Visits to recipients in this group while in inpatient hospitals	X	
2Ø	Pmts. for In Hosp. Svcs.	Total dollars paid for inpatient hospital care for recipients in this group		X
21	No. of Outpatient Svcs.	Total number of services received by recipients in this group from outpatient hospitals	X	
22	No. of Different Out Hosp.	An unduplicated count of individual outpatient hospitals visited by recipients in this group		X
23	Pmts. for Out Hosp. Svce.	Total dollars paid for outpatient hospital services received by recipients in this group		X
24	No. LTCF Discharges	Total number of times recipients in this group were discharged from long term care facilities	X	
25	No. Days in LTCF	Total number of days recipients in this group spent in long term care facilities	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	REPORT ITEM DESCRIPTION

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-RECIPIENT CLASS PROFILES SU-0-Ø1

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED	MINIMAL
26	No. Medical Visits-LTCF	Number of physician Medical Visits to recipients in this group while in long term care facilities	X	
27	Pmts. for LTCF Care	Total dollars paid for long term care facility care for recipients in this group		X
28	No. of Drug Rx	Total number of drug prescriptions filled for recipients in this group	X	
29	No. Refill Rx	Total number of refill drug prescriptions filled for recipients in this group	X	
3Ø	No. of Narcotic Drug Rx	Total number of narcotic drug prescriptions filled for recipients in this group	X	
31	No. of Different Drugs	An unduplicated cant of individual drugs received by recipients		X
32	Pmts. for Drugs	Total dollars paid for drug prescriptions filled for recipients in this group		X

SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-RECIPIENT CLASS PROFILES SU-O-Ø1

ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED MINIMAL	
33	No. of Other Services	Total number of services received by recipients in this group not covered by Report Items listed above		X
34	Pmts. for Other Services	Total dollars paid for services received by recipients in this group not covered by Report Items listed above		X
CC		Averages Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve months, Current Quarter to Date, and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change value covering the last fifteen months is also reported for each Report Item. The Report Item content of this section is identical to that of the Summary Profile Report Recipient. The values of each Report Item, however, are for an average recipient in this Class Group rather than for a specific recipient.	X	
DD		Standard Deviations Section Each of the Report Items in this section is reported for the following time periods: Current Month and Fiscal Year to Date, on a Date Paid basis; Average Month of the past twelve month, Current Quarter to Date and each of the past four quarters, all on a Date of Service basis. A Trend Line Rate of Change Value covering the last fifteen months is also reported for each Report Item.	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		REPORT ITEM DESCRIPTION	
SUBSYSTEM MARS MANAGEMENT SUMMARY REPORT-RECIPIENT CLASS PROFILES			SU-0-Ø1
ITEM NO.	ITEM NAME	ITEM DESCRIPTION	RECOMMENDED / MINIMAL
		The Report Item content of this section is identical to that of the Summary Profile Report-Recipient. The values of each Report Item, however, represent the standard deviation from the average of the corresponding values of all individual recipients in this Class Group.	
EE		Frequency Distributions Section This section contains frequency distributions on Report Items selected by the user. Any Report Item listed in the Summary Profile Report-Recipient may be selected. The report will display a series of value ranges for each Report Item selected, together with a count of the number of times the value of that item for individual recipients in this class group fell into each value range.	X

E. SUBSYSTEM INPUTS

The Management and Administrative Reporting Subsystem receives the inputs listed below. The purpose and source of each input are presented on an Input Definition Sheet. This sheet is followed by an Input Description Form that indicates the data elements that are introduced into the system by means of this input. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claim processing, and effective surveillance and utilization review activities. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix. Not all data elements available in these Input Files are used in the MARS Subsystem.

Input Number	Input Name	Page Number
MR-I-Ø1	Budget Change Form	VII-245
CP-F-Ø5	Claims Processing Control File	VII-247
CP-F-Ø7	Adjudicated Claims File	VII-249
PS-F-Ø1	Provider Master File	VII-253
RS-F-Ø1	Medicaid Eligibility Master File	VII-257
RS-F-Ø3	Buy-In Master File	VII-259

INPUT DEFINITION

INPUT NAME	INPUT NO.
Budget Change Form	MR-I-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Category of Service	Monthly
	MEDIA
	Form

SOURCE OF INPUT DATA

Medicaid Financial Planning Section

PURPOSE OF INPUT

The Budget Change Form will be prepared monthly to introduce financial data into the Management and Administrative Reporting Subsystem in order to compare actual expenditures for medical assistance services with planned expenditures.

REMARKS

The Budget Change Form will be prepared prior to the beginning of each fiscal year and should be revised as planned expenditures change.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Budget Change Form	MR-I-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
301	Category of Service	X	
601	Fiscal Year	X	
602	Fiscal Month	X	
603	Budgeted Amount	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Claims Processing Control File	CP-F-Ø5
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
	Monthly
Transaction Control Number	**MEDIA**
	Disk

SOURCE OF INPUT DATA

Claims Processing Subsystem

PURPOSE OF INPUT

Provide the basic claims processing statistical data required for preparation of Management Reports.

REMARKS

This file will be the basic source of expenditure data, provider participation data, recipient participation data, units of service, claims processing, and other statistical data.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Claims Processing Control File	CP-F-Ø5
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
300	Transaction Control	X	
101	Recipient ID Number	X	
201	Provider Number	X	
352	Date of Entry	X	
353	Transaction Status	X	
312	Beginning Date of Service		X
313	Ending Date of Service		X
354	Input Claims	X	
355	Input Credits and Adjustments	X	
356	Input Prior Authorizations	X	
357	Input Queries	X	
358	Suspense Claims	X	
359	Suspense Credits and Adjustments	X	
360	Suspense Prior Authorizations	X	
361	Previously Adjudicated Claims	X	
362	Previously Adjudicated Credits and Adjustments	X	
363	Suspense Transactions Deleted	X	
364	Total Charge Adjustments	X	
365	Matched Prior Authorizations	X	
366	Adjudicated Claims Output	X	
367	Adjudicated Credits and Adjustments Output	X	
368	Suspense Claim Output	X	
369	Suspense Credits and Adjustments Output	X	
371	Queries Printed	X	
373	Date of Transaction Status	X	
372	Error Codes	X	
375	Number of Corrective Action Attempts	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Adjudicated Claims File	CP-F-Ø7
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71
SEQUENCE	**FREQUENCY**
Transaction Control Number	Monthly
	MEDIA
	Tape or Disk

SOURCE OF INPUT DATA

Claims Processing Subsystem

PURPOSE OF INPUT

Introduce descriptive claims data into the Management and Administrative Reporting Subsystem. Descriptive data includes such claim details as Recipient Number, Provider Number, Claim Payment, Units of Service, Third Party Data, etc.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Adjudicated Claims File	CP-F-Ø7
SUBSYSTEM NAME	**DATE**
Claims Processing	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
300	Transaction Control Number	X	
301	Category of Service	X	
302	Transaction Code	X	
101	Recipient ID Number	X	
103	Recipient Name	X	
107	Recipient Sex Code	X	
106	Recipient Race Code	X	
105	Recipient Date of Birth	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
391	Family Planning Code	X	
303	Attending Physician Number	X	
304	Referring Physician Number	X	
306	Primary Diagnosis Code	X	
307	Secondary Diagnosis Code	X	
201	Provider Number	X	
349	Payment Amount	X	
310	Billing Date	X	
321	Total Claim Charge	X	
328	Third Party Liability Action	X	
329	Third Party Payment Amount	X	
500	Procedure Code	X	
501	Drug Code	X	
315	Refill Indicator	X	
311	Admission Date	X	
312	Beginning Date of Service	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Adjudicated Claims File	CP-F-Ø7
SUBSYSTEM NAME	**DATE**
Claims Processing	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
313	Ending Date of Service	X	
316	Patient Status	X	
317	Discharged Patient's Destination		X
318	Destination Provider Number		X
319	Previous Provider Number		X
326	Blood Not Replaced	X	
322	Procedure Charge	X	
323	Drug Charge	X	
305	Prescribing Physician Number	X	
314	Place of Service	X	
327	Units of Service	X	
330	Medicare Cash Deductible Amount	X	
331	Medicare Blood Deductible Amount	X	
332	Medicare Coinsurance Amount	X	
376	Payment Date	X	
351	Adjudication Status	X	
378	Date of Surgery	X	
379	Leave Days	X	
380	Allowable Procedure Payment	X	
381	Professional Fee	X	
503	Maximum Days Supply of Drug	X	
384	Type of Service	X	
233	Per Diem Rate	X	
386	Prescription Number	X	
387	Approval Authority		X
388	Screening Results Code	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Adjudicated Claims File	CP-F-Ø7
SUBSYSTEM NAME	DATE
Claims Processing	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
389	Screening Referral Code	X	
390	Screening Related Treatment	X	
392	Medicaid Deductible Amount		X
393	Medicaid Copayment Amount		X
397	Operating Physician Number		X
398	Nature of Admission		X
399	Certification Status		X
400	Certification/Recertification Date		X
401	Certification Review Indicator		X
402	Days Certified Initially		X
403	Total Days Certified		X
404	Number of Requests for Extension		X

INPUT DEFINITION

INPUT NAME	INPUT NO.
Provider Master File	PS-F-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Provider Number	Monthly
	MEDIA

SOURCE OF INPUT DATA

Provider Subsystem

PURPOSE OF INPUT

To provide basic provider information to the Management and Administrative Reporting Subsystem. Information will include Provider Identification Numbers (Social Security Number, Federal Employer ID Number, etc.) and fiscal year data.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Provider Master File	PS-F-Ø1
SUBSYSTEM NAME	DATE
Management and Administrative Reporting	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
202	Provider Name	X	
203	Provider Address	X	
204	Provider Pay to Address		X
205	Provider Type	X	
301	Category of Service	X	
207	Beginning Date of Service	X	
208	Ending Date of Service	X	
	(data elements 301 and 207 through 208 are repeated		
	up to 20 times)		
209	Provider Group Number		X
210	Provider Type of Practice Organization		X
211	Provider County Code	X	
212	Provider Employer Identification Number	X	
213	Provider Social Security Number	X	
214	Medicare Provider Number		X
215	Provider Medicare Reimbursement Rates		X
216	Provider Year End Date		X
217	Provider License Number		X
218	Provider License Board Code		X
219	Provider License Date		X
220	Provider Specialty Code	X	
221	Specialty Certification Number		X
222	Specialty Certification Board Code		X
223	Specialty Certification Date		X
	(data elements 220 through 223 are repeated up to		
	three times)		

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Provider Master File	PS-F-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	12/3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
224	Date of Last Transaction		X
225	Provider Exception Indicator		X
226	Provider Credit Balance Amount	X	
227	Provider Credit Balance Date	X	
228	Provider Application Date		X
229	Provider Rejection Reason Code		X
230	Out of State Provider Code		X
231	National Pharmacy Number		X
232	Number of Beds Certified		X
233	Per Diem Rate	X	
234	Percent of Charges Factor	X	
235	Rate Effective Date	X	
	(data elements 233 through 235 are repeated up to		
	five times)		
236	Provider Location Code		X
237	Control of Medical Facility		X
238	Provider Enrollment Status Code	X	
239	Provider Enrollment Status Date	X	
	(data elements 238 and 239 are repeated up to five		
	times)		
241	Number Physicians in Group		X
250	Nursing Home Owners	X	
251	Review Committee Members	X	

I-NPUT DEFINITION

INPUT NAME	INPUT NO.
Medicaid Eligibility Master File	RS-F-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Recipient Number	Monthly
	MEDIA
	Tape or Disk

SOURCE OF INPUT DATA

Recipient Subsystem

PURPOSE OF INPUT

Introduce eligibility and recipient demographic data into the Management and Administrative Subsystem to produce Management Reports.

REMARKS

This file will be the primary source of Medicaid eligibility information.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Medicaid Eligibility Master File	RS-F-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code	X	
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
	(data elements 108 through 111 are repeated ten times)		
112	Date of Death	X	
113	Third Party Liability Code	X	
114	Buy-In Status Code	X	
224	Date of Last Transaction		X
116	Recipient Exception Indicator		X
117	Money Payment Code	X	
118	Medicare Type Code		X
122	Date of Identification Card Issue		X
	(data element 122 is repeated five times)		
123	Buy-In Eligibility Date	X	
124	Scope of Coverage Code		X
132	Recipient Eligibility Certification Date	X	
133	Recipient Location Code		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Medicaid Eligibility Master File	RS-F-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
134	Social Security Account Number	X	
135	Gross Family Income	X	
136	Family Size	X	
137	Medicaid Premium Amount	X	
138	Medicaid Enrollment Fee Amount	X	
392	Medicaid Deductible Amount	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Buy-In Master File	RS-F-Ø3
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Recipient Number	Monthly
	MEDIA
	Tape or Disk

SOURCE OF INPUT DATA

Recipient Subsystem

PURPOSE OF INPUT

To introduce Medicare Buy-In eligibility and accretion data into the Management and Administrative Reporting Subsystem.

REMARKS

This file will be the primary source of Buy-In premium data.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Buy-In Master File	RS-F-Ø3
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address		X
105	Recipient Date of Birth	X	
106	Recipient Race Code		X
107	Recipient Sex Code	X	
108	Recipient County Code		X
109	Recipient Aid Category		X
114	Buy-In Status Code	X	
115	Date of Last Transaction	X	
117	Money Payment Code	X	
123	Buy-In Eligibility Date	X	
129	Buy-In Premium Period		X
130	Buy-In Premium Amount		X
	(data elements 129 and 130 are repeated four times)		
134	Social Security Account Number	X	

F. SUBSYSTEM FILES

The Management and Administrative Reporting Subsystem produces five major files. The purpose and nature of each file is presented on a File Definition Sheet. Subsystem files include:

File Number	File Name	Page Number
MR-F-Ø	MARS Master File	VII-263
MR-F-Ø2	MARS Administrative History File	VII-264
MR-F-Ø3	MARS Operations History File	VII-265
MR-F-Ø4	MARS Provider History File	VII-266
MR-F-Ø5	MARS Recipient History File	VII-267

A Data Element Input/Output Matrix and a Work Item Input/Output Matrix are included at the end of this section. The Data Element I/O Matrix defines the relationship between the subsystem inputs and the subsystem files. The Work Item I/O Matrix defines the content of the subsystem files in terms of work items and shows the relationship between these files and the reports produced by the various Management and Administrative Reporting Subsystem Modules.

As previously discussed, in Section VII-B-2e (Page VII-18), there is a consideration to be made during the detail design phase involving the derivation of work items from data elements which are in turn used to compute report items. In this documentation the data elements, shown on the Data Element I/O Matrix, are used to derive the work items, shown on the Work Item I/O Matrix. The logic of specifying data elements used in deriving each work item is a detail design task. A similar detail design task is required in relating the work items, shown on the Work Item I/O Matrix, to the report items shown on the report format samples.

To better understand this relationship, consider Report Item 6.02 (Number of Providers Participating This Month by Category of Service) shown on the Provider Participation Summary Report (MR-0-Ø6). Beginning with the subsystem inputs, there are four data elements essential in developing this report item:

Data Element 300 - Transaction Control Number

Data Element 301 - Category of Service

Data Element 376 - Payment Date

Data Element 201 - Provider Number

These data elements are extracted from the Adjudicated Claims File (as shown under the input section of the Data Element I/O Matrix) and used to prepare the MARS Administrative History File. The logic, which will be developed during detail design, will probably require the review of each claim record by Transaction Control Number (Data Element 300) to determine the Category of Service and the Provider Number included in the claim. A further check will be made to ensure an unduplicated count of providers is developed. In addition, the payment date (Data Element 376), will be checked to insure that it falls within this month. Each time a new provider number is detected for this month and this category of service, an additional tally will be made to the MARS Administrative History File. This tally will appear in the MARS Administrative History File as the work item - Number Providers Participating During a 13 Month Period (fourth item down on the Work Item I/O Matrix).

As indicated, on the Work Item I/O Matrix, this work item (Number of Providers Participating) is checked on the input side under MARS Administrative History File and on the output side under Provider Participation Summary. In this case the work item becomes the report item but in many cases computations involving two or more work items are required to produce the report item.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DEFINITION

FILE NAME	FILE NO.
MARS Master File	MR-F-Ø1
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Category of Service	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

Updated monthly by data extracted from the Claims Processing Central File, Adjudicated Claims File, Medicaid Eligibility Master File, Provider Master File, Buy-In Master File and the Budget Control Form.

PURPOSE AND FUNCTION

Provides the major source of statistical information in the Management and Administrative Reporting Subsystem. This file is updated monthly to provide an adcumulative history of all system data by time periods and by totals for the fiscal year-to-date. The MARS Master File is read monthly to prepare the four module History Files from which all reports in the subsystem are prepared.

The MARS Master File may be utilized to prepare data to support Federal reporting requirements if desired. The MARS Master File also provides the only historical retention of accumulated provider payment and charge data.

REMARKS

Work items defining the content of this file are listed on the work itemmmatrix in this section.

FILE DEFINITION

FILE NAME	FILE NO.
MARS Administrative History File	MR-F-Ø2
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Category of Services	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

Prepared monthly from the MARS Master File

PURPOSE AND FUNCTION

The MARS Administrative History File is designed to contain all the data essential to processing and computation of information for the Administration Module Reports.

REMARKS

Work items defining the content of this file are listed on the work item matrix in this section.

FILE DEFINITION

FILE NAME	FILE NO.
MARS Operations History File	MR-F-Ø3
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Category of Service	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

Prepared monthly from the MARS Master File

PURPOSE AND FUNCTION

The MARS Operations History File contains claims processing performance data utilized in preparing the reports for the Operations Module. The file contains the basic source of historical claims processing statistics since the Claims Processing Central File is purged monthly.

REMARKS

Work items defining the content of this file are listed on the work item matrix in this section.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DEFINITION

FILE NAME	FILE NO.
MARS Provider History File	MR-F-Ø4
SUBSYSTEM NAME	**DATE**
Management and Administrative Reporting Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Provider Number	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

Prepared monthly from the MARS Master File

PURPOSE AND FUNCTION

Contains the basic provider payment data and statistical data essential in preparation of the Provider Module Management Reports.

REMARKS

Work items defining the content of this file are listed on the work item matrix in this section.

FILE DEFINITION

FILE NAME	FILE NO.
MARS Recipient History File	MR-F-Ø5
SUBSYSTEM NAME Management and Administrative Reporting Subsystem	**DATE** 8/1/71
SEQUENCE Category of Service	**FILE TYPE** [X] EDP [ ] MANUAL

UPDATE PROCEDURE

Prepared monthly from the MARS Master File

PURPOSE AND FUNCTION

Contains recipient-related statistical data extracted from the MARS Master File and used in computation and preparation of Recipient Relations Module Reports.

REMARKS

Work items defining the content of this file are listed on the work item matrix in this section.

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT
INPUT/OUTPUT MATRIX

SUBSYSTEM NAME
Management and Administrative Reporting

INPUT: Budget Change Form (MR-O-01)	INPUT: Medicaid Eligibility Master File (RS-F-01)	INPUT: Buy In Master File (RS-F-03)	INPUT: Provider Master File (PS-F-01)	INPUT: Claims Processing Control File (CP-F-05)	INPUT: Adjudicated Claims File (CP-F-07)	ELEMENT NUMBER	DATA ELEMENT NAME	OUTPUT: MARS Master File (MR-F-01)	OUTPUT: MARS Administration History File (MR-F-02)	OUTPUT: MARS Operations History File (MR-F-03)	OUTPUT: MARS Provider History File (MR-F-04)	OUTPUT: MARS Recipient History File (MR-F-05)
	D	D		D	D	101	Recipient ID Number	W	W	W	W	W
					D	103	Recipient Name	W			W	
					D	105	Recipient Date of Birth	W	W			W
					D	108	Recipient County Code	W				W
					D	109	Recipient Aid Category	W	W			W
	D					110	Eligibility Begin Date	W				W
		D				114	Buy-In Status Code	W	W			W
		D				130	Premium Amount	W	W			
	D					132	Approval For Assistance Date	W				W
			D	D	D	201	Provider Number	W	W		W	W
			D			202	Provider Name	W			W	
				D		203	Provider Address	W			W	
			D			212	Provider Employer ID Number	W			W	
			D			213	Provider Social Security Number	W			W	
			D			214	Medicare Provider Code	W			W	
			D			216	Provider Year End Date	W			W	
					D	233	Per Diem Rate	W			W	
				D		234	Percent of Charges Factor	W			W	
				D		235	Rate Effective Date	W			W	
				D	D	300	Transaction Control Number	W	W	W	W	W
					D	301	Category of Service	W	W	W	W	W
					D	302	Transaction Code	W	W	W		
					D	306	Primary Diagnosis Code	W			W	
					D	307	Secondary Diagnosis Code	W			W	
					D	312	Beginning Date of Service	W			W	
				D	D	313	Ending Date of Service	W		W	W	
					D	321	Total Claim Charge	W	W	W	W	W
					D	322	Procedure Charge	W			W	
					D	327	Units of Service	W	W	W	W	W
					D	328	Third Party Liability Code	W			W	
					D	329	Third Party Payment Amount	W			W	
					D	330	Medicare Cash Deductible Amount	W			W	
					D	331	Medicare Blood Deductible Amount	W			W	
					D	332	Medicare Coinsurance Charge	W			W	
					D	349	Payment Amount	W	W	W	W	W
				D		352	Date of Entry	W	W	W	W	
				D		372	Error Code	W		W	W	
				D		373	Date of Transaction Status	W	W	W		
				D		375	No. Corrective Actions	W		W	W	
					D	376	Payment Date	W	W	W	W	
				D	D	377	Transaction Status	W	W	W		
					D	388	Screening Results Code	W	W			W
					D	389	Screening Referral Code	W	W			
					D	390	Screening Related Treatment	W	W			
	D					137	Medicaid Premium Amount	W				W
					D	392	Medicaid Deductible Amount	W				W
					D	393	Medicaid Copayment Amount	W				W
					D	500	Procedure Code	W			W	
					D	501	Drug Code	W				W
D						601	Fiscal Year	W	W			
D						602	Fiscal Month	W	W			
D						603	Budgeted Amount	W	W			

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

WORK ITEM
INPUT/OUTPUT MATRIX

SUBSYSTEM NAME

Management And Administrative Reporting

INPUT								OUTPUT																			
MARS Recipient History File (MR-F-05)	MARS Provider History File (MR-F-04)	MARS Operations History File (MR-F-03)	MARS Administration History File (MR-F-02)	MARS Master File (MR-F-01)	WORK ITEM NAME	Medical Assistance Financial Status (MR-O-01)	Medical Assistance Program Status (MR-O-02)	Financial Summary (MR-O-03)	Expenditure Analysis (MR-O-04)	Medicare Participation Analysis (MR-O-05)	Provider Participation Summary (MR-O-06)	Operations Performance Summary (MR-O-08)	Claims Processing Performance Analysis (MR-O-09)	Claims Processing Thruput Analysis (MR-O-10)	Error Distribution Analysis (MR-O-11)	Provider Participation Analysis (MR-O-12)	Cost Settlement Analysis (MR-O-13)	Cost Settlement Details (MR-O-14)	Provider Claim Filing Analysis (MR-O-15)	Provider Claim Filing Details (MR-O-16)	Third Party Payment Analysis (MR-O-17)	Error Frequency Analysis (MR-O-18)	Provider Ranking List (MR-O-19)	1099-MED (MR-O-20)	Drug Usage Frequency Analysis (MR-O-21)	Recipient Participation Summary (MR-O-22)	County Participation Analysis (MR-O-23)	County Expenditure Analysis (MR-O-24)	Benefit Usage Analysis (MR-O-25)	Drug Usage By Eligibility Class (MR-O-26)
W	W	W	W	W	Category of Service	R	R	R	R		R	R	R	R	R	R		R	R	R							R	R	
W			W	W	No. Claims (1)						R																R		
W			W	W	No. Providers Enrolled (1)		R				R															R				
	W		W	W	No. Providers Participating (1)		R				R					R														
	W			W	No. Third Party Claims (1)											R														
	W			W	Amount of Third Party Payment (1)											R														
W			W	W	Aid Category (5)				R																R	R	R	R	R	R
W		W	W	W	Eligible Recipients (3)		R				R	R														R			R	
W		W	W	W	Participating Recipients (3)		R		R			R				R										R			R	R
W		W	W	W	Service Units (3)		R	R	R			R				R													R	
W				W	Days Eligibility to Cert. (3)																					R				
W		W	W	W	Title XIX Payments (3)	R	R	R	R			R				R										R				
W				W	County Number (4)																						R	R		
W		W	W	W	Eligible Recipients (4)						R	R														R	R			
W		W	W	W	Participating Recipients (4)				R			R				R										R	R			
W		W	W	W	Title XIX Payments (4)			R	R			R				R										R	R	R		
			W	W	Fiscal Year Budget (1)	R		R																						
		W		W	Claims Processed (2)										R															
		W	W	W	Number New Claims Approved (1)		R				R	R	R			R														
		W	W	W	Number New Claims Processed (1)		R					R	R			R														
		W	W	W	Number New Claims Rejected (1)		R						R			R														
		W		W	Number New Claims Suspended (1)								R			R														
		W		W	No. New Claims Suspended More Than Once (1)								R																	
		W		W	Number New Claims Released (5)								R																	
		W	W	W	Old Claims Released (1)		R					R	R			R														
		W	W	W	Old Claims Approved (1)		R				R	R	R			R														
		W	W	W	Old Claims Rejected (1)		R					R	R			R														
		W		W	Old Claims Suspended (1)							R	R			R														
		W		W	Old Claims Suspended More Than Once (5)							R	R																	
		W	W	W	Claims Overrode (5)		R						R		R											R				
		W	W	W	Claim Amount In Process Mo.End (1)			R				R														R				
W			W	W	OAA Recip. Elig. for Medicare (1)					R																R				
W			W	W	Eligible Buy-In Recipients (1)					R																R				
W			W	W	Certified Buy-In Recipients (1)					R																				
			W	W	Total Buy-In Premium (1)					R																				
		W		W	Beginning Suspense File Balance (5)							R	R																	
		W	W	W	Ending Suspense File Balance (5)		R					R	R																	
		W		W	Paid Claims With 1-2 Errors (5)										R															
		W		W	Paid Claims With 3-5 Errors (5)										R															
		W		W	Paid Claims With More Than 5 (5)										R															
W				W	Drug Quantity (3)																						R			
	W		W	W	XVIII Payments (1)					R																				
			W	W	XVIII Claims (1)					R																				
			W	W	XVIII Payments Pending (1)					R																				
			W	W	Medicare Payments (1)					R								R												
		W		W	Days Service To Approval (1)							R																		
		W	W	W	Days Entry To Approval (1)		R					R		R																
	W			W	Provider Number											R	R	R	R	R	R	R	R	R						
	W			W	Provider Name (6)												R						R	R	R					
	W			W	Title XVIII Provider Number (6)												R													
	W			W	Provider Social Security Number (6)																					R				
	W			W	Employed ID Number (6)																					R				
	W			W	Fiscal Year End Date (6)												R													
	W			W	Charge Code (6)												R													
	W			W	Charge Amount (6)												R	R												
	W			W	Payment By Other Source (6)													R												
	W			W	Last Year Reimbursement (6)												R													
	W			W	Last Year Charges (6)												R													
	W			W	Third Party Payments-12 mos. (7)													R				R								
	W			W	Third Party Claims - 12 mos. (7)																	R								
	W			W	XIX Total Payment - 12 mos. (7)												R	R	R	R	R	R		R	R					
	W			W	Number Claims - 12 mos. (7)														R		R	R	R							
	W			W	Days Service to Entry (7)															R										
	W			W	Claim Filing Days (7)														R	R										
	W	W		W	Error Code (7)										R								R							
	W	W		W	Error Count (7)										R								R							
	W			W	Per Diem Rate (7)													R												
	W			W	No. Claims More Than 1 Error (7)																			R						
	W			W	No. Claims Overrode (7)																			R						
	W			W	XIX Claims Approved - 12 mos. (7)																			R						
W				W	Drug Classification (3)																					R				
W				W	Drug Amount (3)																					R				
W				W	Number of Prescriptions (3)																					R				

See following page for explanation of footnotes.

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

WORK ITEM
INPUT/OUTPUT MATRIX

SUBSYSTEM NAME
Management And Administrative Reporting

INPUT						OUTPUT			
MARS Recipient History File (MR-F-05)	MARS Provider History File (MR-F-04)	MARS Operations History File (MR-F-03)	MARS Administration History File (MR-F-02)	MARS Master File (MR-F-01)	ELEMENT NUMBER	DATA ELEMENT NAME	Periodic Screening Cost Analysis (MR-O-27)	Recipient Cost Sharing Analysis (MR-O-28)	Cost Settlement Details (MR-O-14)
W				W		Recipient Age Group	R		
W				W		County Number	R		
W				W		Total Children - Screened	R		
W				W		Total Children - Not Screened	R		
W				W		Total Claim Cost - Screened	R		
W				W		Total Claim Cost - Not Screened	R		
W				W		Average Cost - Screened	R		
W				W		Average Cost - Not Screened	R		
W				W		Category of Service		R	
W				W		Number Claims		R	
W				W		Cost Sharing Amt - Total		R	
W				W		Cost Sharing Amt - Average		R	
W				W		Average Claim Payment		R	
W				W		Average Claim Cost		R	
W				W		Premiums Collected		R	
W				W		Total Deductible and Copayments		R	
W				W		Total Cost Sharing Contributions		R	
	W			W		Provider Address			R
	W			W		Char e Center			R
	W			W		Reimbursement Mode			R
	W			W		Reimbursement Factor			R
	W			W		Rate Effective Date			P
						Recipient Name			D
	W			W		Recipient ID Number			R
	W			W		Transaction Control Number			R
	W			W		Date Paid			R
	W			W		Service Dates			P
	W			W		Diagnosis Codes			R
	W			W		Days Regular/Nursery			R
	W			W		Charges			R
	W			W		Medicaid Payment			R
	W			W		Third Party Payment			R

Footnotes:

(1) Work Element By 13 Monthly Periods and FYTD Last Year And Category of Service.

(2) Processed Within 10, 20, 30, 45, 60 Or More Than 60 Days and Category of Service.

(3) Work Element By 13 Monthly Periods, FYTD Last Year, Category of Service and Aid Category.

(4) Work Element By Category of Service and Aid Category.

(5) Work Element By Category of Service Only.

(6) Work Element By Provider Number.

(7) Work Element by Provider Number and Category of Service.

(8) In the Input Section "W" Indicates The Work Items Contained in the Mars Input Files As Shown.

(9) In the Output Section "R" Indicates The Work Items Used to Produce Report Items in the Output Reports As Shown.

U.S. GPO 1975/620-293/2221

CMS LIBRARY
3 8095 00014340 0

INTRODUCTION

SUMMARY

DESIGN ELEMENTS

PROCESSING FLOW

OUTPUTS

INPUTS

FILES

DATA ELEMENT I/O MATRIX

WORK ITEM I/O MATRIX

SRS75-06004